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A MEDICAL JOURNAL CONTAINING

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ORGANIZED MEDICINE; ITS INFLUENCE AND ITS OBLIGATIONS *

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CHICAGO

It is the purpose of every man's life to do something worthy of the recognition and appreciation of his fellow-men. There is no accomplishment of mine of sufficient importance to have merited the honor which you have conferred on me in electing me President of the American Medical Association, with its 34,000 members—the largest and perhaps the most influential body of medical men in the world. For your generosity in thus honoring me, I am most grateful. The span of man's activity is so short that many who are most worthy cannot receive this honor: that you should have conferred it on me affects me profoundly. In return for your confidence it will be my pleasure to give my best energy, thought and judgment to the welfare of the American Medical Association during the ensuing year.

ANNUAL MEETING

I would suggest two innovations in the programs of the annual sessions of the American Medical Association. The first has been devised and experimentally inaugurated at this meeting by the chairman of the Committee on Preventive Medicine and Public Health, Dr. W. A. Evans. It consists of a series of lectures and demonstrations to the public and should be made a part of the annual exercises. The second is a recommendation to the House of Delegates that there be two clinical days before and two after the meeting.

In regard to the first, it is not quite in keeping with the larger economics of to-day that the American Medical Association should annually gather a large number of medical luminaries and have them depart without leaving lasting impressions on the public mind of the community in which the meetings are held. Advantage should be taken of these occasions to produce a spirited public awakening in medical and health truths. There should be an extensive and accurately planned course of instruction on health and disease by the master teachers of the profession through lectures, exhibitions, lantern demonstrations and moving pictures. These should be free from technicalities and pedantry, should bristle with information but should be presented in a simple, comprehensive and attractive manner.

Concerning the recommendation for clinical exercises in connection with the annual session of the American Medical Association: Most of the members devote at least a week to the meeting, so there would be no special loss of time. The clinics should be in charge of the section officers who should select the ablest teachers in their special line. The material for the purpose of demonstrating pedagogic principles, diagnostic points, clinical results, etc., may be supplied by the local profession or brought from a distance. These clinics should not interfere with the general or section sessions. Information imparted in this way is far more attractive as well as instructive to the attending members than papers and discussions. If deemed advisable, inquiry and discussions may be carried on at the clinics. The Society of Clinical Surgery has demonstrated beyond question that clinical meetings are most attractive, instructive and inspiring and are the best means of advancing, coordinating and standardizing medical information. A striking example of the enthusiasm, appreciation and desire for this type of meeting was brought out in the first Congress of Surgeons of North America, organized by Dr. Franklin H. Martin and held in Chicago, in November, 1910. A still further evidence in favor of these clinics, if one be needed, is the ever-increasing attendance of busy practitioners in the surgical and medical clinic arenas. Men are inspired by seeing others doing and in action rather than reading or hearing about them. The clinics should be on diseases of the every-day type, accentuating the most recent advancement in diagnosis and treatment rather than surgical operations or demonstrations of unique and rare cases, except when these support or establish new principles. Methods of teaching should be particularly emphasized. Clinical pedagogy has received little or no attention, and as clinics involve one-third of the time of the medical students, it calls for active and definite lines of procedure in order to secure the best results. I feel that these clinics will increase the interest, enhance the educational value and double the attendance at our annual meetings.

INCREASE IN MEMBERSHIP

Let us next consider how the American Medical Association can be made more serviceable to the whole American medical profession and therefore to the American people. The first question is, shall the membership be increased? An increase in our membership is necessary for many reasons. First: The great volume of work demanded of the organization requires funds and this necessitates a larger membership. Second: The accomplishment of this work requires the influence of all the respectable and redeemable members of the medical profession in the remote districts, as well as in the great centers of our commonwealth. It is impossible to say how many of the men who have graduated in medicine remain affiliated with medicine and continue to practice. Of the 140,000 medical men in the United States, according to the second edition of the American Medical Directory, at least 100,000 should belong to this organization. The practical doubling of the present membership from 35,000 to 70,000 should be an

* President's address before the American Medical Association, at the Sixty-Second Annual Session, at Los Angeles, June, 1911.

easy matter when we have in the states over 55,000 doctors receiving The Journal. Surely every one of these should be an active member. Nearly 75,000 have joined the county societies, and only 35,000 of these are members of the American Medical Association. The remaining 40,000 should be active members of this organization within the next twelve months as they have taken the first step, namely, the establishment of their eligibility to this association. I hope that Dr. Thomas McDavitt, of St. Paul, chairman of the Committee on Uniform Regulation of Membership in County Societies, will, at this meeting, report a practical plan for the increased admission of members to the County Societies. What percentage of the doctors in the various states do not belong to the American Medical Association? It ranges from 77.5, 76 and 75.5 per cent. in Mississippi, Arkansas and Tennessee, respectively, to 33, 38 and 40 per cent., respectively, in Utah, North Dakota and Minnesota.

The method of becoming a member of the American Medical Association could be improved. When a man joins his county medical society he does not become a member of the American Medical Association; he becomes only eligible to membership. In some states a membership in the county society carries with it a membership in the state medical society. In other states the county membership establishes only eligibility to the state society. A committee of the Board of Trustees has already been appointed to consider this question. I recommend that this committee be enlarged by adding a number of members of the House of Delegates, and that this joint committee act promptly in bringing about such changes in the Constitution or By-Laws as is necessary to make every member of a county society a member of the American Medical Association. This could be easily carried out were it not for the difficulty of adjusting the relative finances of the county, state and national associations. A small fee for admission to these societies, say $1, to be collected by the state or county organization, and a portion of it forwarded to the other organization and the American Medical Association, would probably be the best plan, under the existing conditions. Careful consideration should be given the amount of the annual dues. This should be computed on the basis of the direct or indirect benefit derived by the individual from his connection with the Association. A $5 annual due is much too large for a great and widely distributed membership if nothing additional is done for its members. If, on the other hand, one or more periodicals are distributed, courses of study are furnished, lectures are made available, pamphlets, text-books, etc., are provided at a saving, a medical defense is instituted, places for self and society help installed, inferior competition controlled, the practice made more honest and the public educated—the annual dues of $5 are less than the profession will be willing and anxious to pay and less than the Association will need for the work, however economically it may be administered. If a membership in the Association is *only a paper asset*, a $1 due will be collected with difficulty. The Association must be actively doing for its members in many and divers ways; some of them direct, others indirect. The indirect benefits derived from the Council on Medical Education, the Council on Pharmacy and Chemistry, colossal though they be, are not appreciated by the average medical man, although he is a gross debtor to the organization for these services, be he a member or non-member.

The fixed charges, as administration expenses, cost of maintenance of the Council on Pharmacy and Chemistry, the Council on Medical Education, the Council on Health and Public Instruction and the Judicial Council, which I shall presently advocate, should not be decreased but rather increased if necessary to advance their efficiency. The largest item of expenditure is for the maintenance of The Journal of the American Medical Association, which is now the best journal of its kind in the world, printed in any language. Its position must not only be maintained but it must be the leader in the medical progress of our time. Our pride in it is justifiable. Besides its great prestige as an educator, it is the best business asset of our organization, for which Dr. Simmons, the Editor and Manager, deserves great credit.[1] Its character must not be altered, notwithstanding the fact that it is becoming too technical for many of its readers and would be still less advantageous to the additional number which we wish to draft into the Association through the state and county medical societies.

THE JOURNAL ADVERTISEMENTS

With a membership of 100,000, is it possible to reduce the price of The Journal and recoup the difference by increasing the number of advertisements and their rates? Such a Journal would no doubt have a circulation of 125,000, including subscriptions from non-members, and would mean 6,500,000 copies a year. This large circulation would make it attractive to advertisers who had never made use of the medium of medical journals before.

Under those circumstances I can see no reason for refusing any advertisement of a reputable character, which tells the truth—the dividing line between the good and bad in advertisements everywhere. One of the great pioneer, praiseworthy works of The Journal of the American Medical Association is that it has always demanded clean advertisements and insisted that advertisers of medical products in and outside of the profession shall tell the truth. This rule is extending to the better class of newspapers, periodicals and magazines. It might be that a vigorous advertising policy along these lines would increase the revenue of The Journal sufficiently to take care of the added cost of a large circulation, so that The Journal could be furnished to the members at a reduced price.

SMALL JOURNALS

There is still a larger field open to this great educational organization. There are many general practitioners who are keen, earnest, industrious, over-worked and ethical men, who desire and require scientific medical assistance. They are diffident and reluctant to ask for it. It should be the purpose and accomplishment of this body to deliver to them this information. The channel most available is by the establishment of a dollar monthly periodical, this to contain working abstracts of articles in the larger journal, original articles on the pathology, diagnosis and treatment of the more common ills, such as malaria, typhoid, diphtheria, tuberculosis, syphilis, hookworm, etc., brought up to date and by authorities, so that a man may have the latest information on the every-day diseases at his command. This will appeal to many practitioners who have had only a moderate amount of technical training and are unfamiliar with the more recent nomenclature. It

1. Secretary's annual report to the Board of Trustees, February, 1911.

can carry in addition, personal news, medical economics, courses of instruction, legal decisions on medical subjects, write-ups on climate, states, cities, hospitals and men; in other words, a breezy, gossipy, personal helpful magazine containing a large percentage of the most modern practical medical facts.

I would recommend to the House of Delegates that a special committee be appointed to investigate and report on the practicability of such publication.

THE COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

The work of this Council, of which Dr. Henry B. Favill is chairman, can best be appreciated by an analysis of a report of its secretary, Dr. Green. It has been all that we should anticipate or expect since its reorganization. Health has received more attention than public instruction. It is my belief that public instruction in medicine is one of the most important functions which the American Medical Association has to perform. The first and all-pervading idea of our medical heritage is the public—the people—and concretely the patient. The latter is the center of the medical universe, around which all our works revolve and toward which all our efforts tend. For centuries the medical profession has criticized the public for its lack of judgment in its selection of doctors. The public has employed the quack; it has employed the irregular or sectarian; it has employed the psychopathic and Christian Science healer; it has employed the bone-setter, the chiropractor, etc. These were employed not alone by the ignorant, the foreigner or the poor, but by the so-called "intelligent, reasoning, educated" and wealthy people of every community. They place a greater amount of confidence in all of these healers and more enthusiastically support them than they do the regular members of the medical profession. Why? Are they more skilful? Are they more worthy of confidence and support? Not at all! But they give the patient some kind of explanation or reason or working hypothesis for the results they attempt to obtain or claim they secure. In other words, they educate the people in their theories, beliefs or sophistries and that is what the public wants, in fact, what it demands. What has the regular medical profession done to educate the public in the last three centuries? Nothing! We have demanded of the public our acceptance on blind faith and the age of blind faith in individuals is passed. What have we taught them of the real truths or principles of scientific medicine? Nothing! What beacon have we set for the layman to assist him in the selection of a skilful practitioner? None! Still, we daily condemn him for his lack of judgment in these matters. The people should be educated in the basic principles of medicine through the publication of articles in the daily or weekly press. These articles should be prepared with the greatest care so as to present the facts in a scientific yet comprehensive manner. There should be established in every large city subcommittees for "lay press publications," so that, when the layman wishes authoritative information in any particular line, he can write to the press and it, through this committee, can give him a clean-cut, positive and authentic report on what has been accomplished in any particular line. If the local committee lacks the information desired, it can be obtained from the central council on public education.

Still further—the Council on Health and Public Instruction should supply the lay press with extensive articles, not alone on the novelties but on the common diseases, giving the people plain information on the true nature, etiology, means of transmission, early signs of disease, etc. How much the mortality of the acute surgical diseases, the acute medical diseases as scarlet fever, diphtheria, pneumonia, etc., and the chronic diseases, as cancer of the lip and breast, tuberculosis, etc., could be reduced if the laity had a little instruction from the profession as to their early recognition, the danger of delay and the line of action in their treatment!

Up to date, the "patent-medicine" almanac, quack advertisements and leaves of healing have been the principal instructors of the public. In addition to this, it has been served by enterprising reporters with accounts of addresses, clinics, etc., in which truth and science are violated in almost every line and with the facts garbled and presented in the most sensational manner. Unfortunately the public accepts these as truths. So long as the above continue to be the only sources of public education, just so long the public will be their patrons. When we supply it with its medical education based on science it will become affiliated with us and sustain us in our every effort. If it were known that the business of this committee was to give authoritative information, the newspaper editors would appeal to it regularly. The education of the public is the most important obligation of this Association. As this advances, our science and our art will receive the admiration and support which true worth once understood always commands.

THE PHYSICIAN'S STATUS PRÆSENS

In society there is division of labor. Honors and financial support are given to those who serve the community well: the indifferent receive meager or no support. This is true of organizations and of men. Being true, it is profitable to inquire what is the standing of physicians?

We find that *certain* medical men are better supported by the community than medical men have ever been in the history of the world, but the *average* medical man is not so well paid as he was twenty years ago and the earnings of a large group are less than the earnings of those belonging to organized labor. Especially noticeable is this when we compare the declining earnings of general and "contract" practitioners with the advancing earnings of artisans and the increase in the cost of living. Society cannot afford to support its physicians indecently. It demands of them a certain standard of living but does not pay them legitimately enough to maintain that standard. The results are manifold but they all amount to the same thing. Physicians therefore are forced to obtain, legally or otherwise, enough to bring them a living income. They cannot have money or leisure for study and books and the community receives poor and out-of-date service commensurate with its payment. They lose in moral stamina and become quacks, advertisers, commission men, fee dividers, professional witnesses, etc.

For these sins I am not excusing the medical profession; I am using this high office—the presidency of the most powerful medical organization in the world—to say to legislative bodies that the horrible cost of poor medical service in invalidism and mortality falls on the community and that for it the community is greatly to blame, because its legislators have almost universally failed to enact sufficiently strict state laws controlling the practice of medicine; notwithstanding the repeated and urgent requests made by the profession for their enactment, they have not demanded, through their respective state boards, a high standard of education for

license to practice; they have not prohibited quackery in all its forms by an adequate penal code; they have not supported the medical profession in its altruistic efforts to render to the people a better service. There must be a national, legal standardization of medical educational institutions and medical practice laws corresponding to that controlling interstate commerce.

The remedies I can only touch on lightly. They lie in a better equalization of the supply of and demand for medical men; better preparation for the art of practicing medicine to be brought about by better medical colleges, supported by private endowment, or by the state if necessary, and the legal suppression of incompetent ones.

COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education, of which my colleague, Dr. A. D. Bevan, is chairman, has won distinction and should receive the highest commendation of this organization. The work it has accomplished in a few years is marvelous when we consider the personal and financial obstacles which it has encountered and overcome. The number of medical colleges in the United States granting degrees has been decreased through the efforts of this committee from 166 in 1904 to 129 in 1911! Of this number only sixty are doing really acceptable work. The number of medical students has been reduced from 28,142 in 1904 to 21,526 in 1910 and the number of graduates for the same period from 5,747 to 4,440. The greatest effect of its labor is in the general uplift of the standard of admission to the medical schools. Twenty-eight medical schools are now requiring as a minimum for entrance two or more years of work in a college of liberal arts, in addition to a four-year high-school education. Ten additional colleges require one year plus the high-school course. There will be four added to the latter in the present year. Thirty-five per cent. of all medical students in 1910 and 1911 were enrolled in the higher grade colleges. They deserve credit for the grading of the medical courses; the increased final requisites for graduation; the elevation of the standard by state boards for admission to state examinations (eight now require preliminary work in a college of liberal arts before entering a medical school); and the stimulation in the public mind of interest in the higher medical education. This Council has completed two tours of inspection of all of the medical colleges in the United States and is now entering on its third.

The admirable work of this Council should be supported financially by the Board of Trustees and morally encouraged by every member of this organization and every one interested in higher education. Its report should be carefully read by all the members of the profession.

MEDICAL EDUCATION

I cannot refrain from sounding a note of warning in connection with medical education, lest we become faddists. In the medical college of thirty years ago a large percentage of the professors were "chosen for chairs" in the college faculty because they had attained some local or national reputation as practitioners; were friends or associates of one who had the organization of the new school in hand; or possessed the all-essential requirement—a sufficient amount of money to invest in the stock or partnership. These selections were often made regardless of the professors' special knowledge of the subjects they were to teach or their ability to impart it if they possessed it. The students were forced as a requirement for graduation to sit for hours each day within the hearing of men ill informed and incapable of teaching. There were, however, many very able teachers in the colleges, though selected in this hap-hazard way. This condition did not exist alone in the third-class schools but in the first and second (modern classification). To be relieved of this we all looked forward to the time when the university would take charge of medical education; when the professor or teaching head of a department would be selected because he was particularly well informed on his subject, and could better instruct the student. The university control is here but with what result to the student? The departmental head is now a man of world-wide reputation as an original investigator, a discoverer, laboratory expert, etc.; but as a teacher, one capable of imparting information to a student or a class in an acceptable and attractive manner, he would not, in a considerable percentage of cases, receive a grading of C in a third-class medical school (Flexner's estimate), notwithstanding his abundant information on the subject. Original investigators ride their hobbies in the class-room to the exclusion of much accepted information in their branches which the student needs more than he does the individual's special trend of thought now given him.

The president and the faculty of a university should elect as teaching head of departments men capable of imparting information with force and in such a way as to be grasped, appreciated and retained by the student body.

There is a place and a first one for the special investigator, the discoverer, the laboratory and the original research man, but it is not in the delivery of the products of medical attainment to the student (unless he possesses special qualification as a teacher) that the best results in medical education can obtain. The laboratory idea has dominated education for the past decade. Much of the instruction has been given from a purely scientific standpoint; the department has been controlled by purely scientific men who had little or no knowledge of medical practice—often not even medical graduates—and they fail in establishing a relationship between the scientific facts and disease. The mission of the university medical department is not primarily the training of original investigators, but of educating physicians for the practice of medicine, i. e., training men who can apply the scientific knowledge to the patient, who is the hub of medical education. In the first one-half or three-fifths of the medical course of the modern university, the student is not brought in contact with the patient at all, and when he enters the junior or senior class, though overflowing with isolated scientific facts, he is woefully incapable of applying his scientific knowledge to the patient. The clinical phase has been in a minor rôle dominated by the laboratory idea. If pure science is to be the all-absorbing topic of medical education for the first two years, then a fifth year must be added to the curriculum, which should be, preferably, an internship in a good hospital. Laboratory research, experimentation, chemistry and bacteriology must all aid in the prevention of disease, and assist in the interpretation of symptoms, physical signs, clinical history into their pathologic entities and their etiologic factors—the only basis for rational therapeutics and the highest attainment in medicine, next to the original discovery of principles.

In order to meet the educational requirements for matriculation in the modern medical school, the young

man is forced to keep his face in the folds of books from his infancy. He has had no opportunity to think, he has not been taught to think, he is a book-stuffed, machine-made, non-thinking automaton albeit a fit and acceptable applicant, according to present requirements, from which a medical school is *supposed* to make a thinking medical man. What marvelous powers a medical school must possess! How is it possible? What changes should be instituted in the evolution of the medical embryo?

Independent thought comes from men whose minds have not been warped by too close adherence to books and the thoughts of others but whose interests have been evolved by individual work and observations, and seeing others work rather than reading of it. An old Arabian proverb reads: "A fig-tree looking on a fig-tree becomes fruitful." An entrance examination of every student should be made by a committee in each state appointed by the Council on Medical Education, to determine his intellectual capacity. In addition to this, account should be taken of his previous condition of servitude at books, in schools and in other occupations. His first year should be one of probation, after which time a competent examining body should pass on his fitness to continue his course. There should be a readjustment of the curriculum so as to give a better-balanced instruction ration and thereby develop more serviceable practitioners as a finished product of medical college education.

GRADUATE STUDY

When a license to practice has been granted a graduate of a medical school it should be only for a period of, say five to ten years, at the end of which time he should be required to pass an examination or take a prescribed course of study. This provision is necessary to keep the general profession abreast of the times. A few enthusiastic men endeavor to accomplish this result now without the legal license requirement, by attending every year or two a course of postgraduate or clinical instruction, in their own or foreign countries. This would greatly improve the efficiency of the medical profession and the trusting public is entitled to it. This plan is not so novel as it seems, as in both the army and navy services periods of demonstrations of mental as well as physical fitness are required.

The development of postgraduate medical teaching in the county medical societies would be advantageous as an educational factor. The excellent courses of study outlined by and put into effect by Dr. Blackburn, of Bowling Green, Ky., in the Warren County Medical Society, should be used as a model. The educational features so ably represented by Dr. McCormack should expand from an individual labor to an organized machine, working through many men and reaching every reputable or redeemable member of the medical profession. No scheme or plan for the betterment of physicians in this country is workable that does not provide for strengthening medical societies—and to be specific—the American Medical Association and its component parts. Postgraduate college work should be controlled by the medical departments of universities. This most important branch of medical training should not be allotted to private corporations any more than undergraduate medical training.

POLITICAL ECONOMY

In every plan of social settlement there are two sets of agencies, governmental and extragovernmental. When the former fails in doing the work, philanthropy, charity, or good citizenship takes up the burden and society leans on it until a public sentiment is created, forcing the government to act—as in the prevention of tuberculosis, child welfare, etc.

The work of advancing medical science, of conducting experiments, of carrying on research, of discovering truths, of devising methods, of educating physicians, of holding them to ethics, of supplying them with modern information, of keeping them honest, upright and courageous—all these, society should itself be doing through government. Since it has failed, we of the profession are forced into the breach and at our own expense are carrying society's burden.

In Italy, the governmental principle has been established. On June 9, 1910, the Italian Chamber of Deputies and the Senate passed a law that every practicing physician in Italy and the provinces must belong to the national society called "The Order of the Doctors." It has absolute control of its members in all matters except in criminal or malpractice proceedings.

I recommend a careful study of this example of political economy, not only by the House of Delegates of the Association, but by political economists of the country. Until such time as our government is prepared to take these advanced steps, we should occupy ourselves with the study of methods whereby the American Medical Association can be made more serviceable to the American public. This Association will miss one of its greatest opportunities if it does not consider its duties outside of those directly concerning the medical profession.

The brunt of labor and expense in research has fallen on the profession. In some directions the results benefit the profession in a material way; in the majority of cases, however, they decrease the revenue of physicians, but greatly benefit the public. These scientists receive as a rule no compensation for their labor and, when a great discovery is made, a new principle established, or a life-saving invention produced, they never receive the same reward that comes to the discoverer or inventor in other fields.

DEFENSE OF MEDICAL RESEARCH

The right to conduct animal research is fought for by medical men almost single-handed. The contest for a national department of health for the prevention of disease has been made in the main by medical men. The struggle for health legislation is made mostly by medical men. Can any one doubt the sincerity of the medical profession in these struggles when their accomplishment means a great reduction in its revenue? The efforts of the general public and the profession should be cooperative, never antagonistic, to obtain the best results.

What is the character of the people in opposition to this work and what is the character of the natural force which is more deadly than opposition?

The opponents are ill-balanced sentimentalists—people with limited capacity for estimating educational or health factors—people without capacity for perspective (such as the antivivisectionists and antivaccinationists), and people with less intellect or integrity than any of these; half-way medical men, as osteopaths, chiropractors, etc.; people with theoretic creeds whose basic belief is against the physician in its sorry attitude, such as a minority of Christian Scientists; the suppressed patent and proprietary medicine venders of worthless or dangerous drugs; a group of men who have suffered financial loss through a growing demand made and fostered by this organization, that advertisements in newspapers, magazines, proprietary and "patent-medicine" pseudo-

medical journals, shall not lie; those whose often criminal and always fake practices have been destroyed by exposure through the medical profession; and lastly a group of erstwhile convicted criminals thirsty for revenge, now of quasi-respectability, affluence and power, whose past reeks with obscenity, vulgarity, immorality or crime.

The gross and unpardonable indifference of the people to their own physical welfare, that of their children and neighbors, is more discouraging and a greater barrier to progress than active opposition. It requires some great calamity to arouse the dormant public mind to an appreciation of its interests and its responsibilties and to the penalty it pays for inactivity.

A HEALTH JOURNAL FOR THE LAITY

How can we make the people see and understand that the obligation is theirs more than ours? How can we affiliate the people if not induce them to take the lead?

I would respectfully recommend the establishment by this organization of a health journal for distribution to the laity. It should have as associate editors, sanitarians, sanitary engineers, sewage and water engineers, sociologists, tenement workers, school teachers, child welfare workers and others with allied purposes. Such a journal should appeal to the general public, to the commercial interests, to the employers of labor, to the school boards, and more especially to mothers and home interests.

This journal should be self-sustaining financially. I suggest that the House of Delegates at this meeting appoint a committee to confer with the American Public Health Association on this very important matter.

ASSOCIATE MEMBERSHIP

I respectfully recommend that the By-Laws be so amended as to provide for an associate membership, admitting those who are making a life-work of or special effort for the betterment of the physical condition of man, as the noble bodies of non-medical men and women who are fighting tuberculosis, infant mortality, bad milk, bad water, and bad housing. These workers logically belong with us as well as medical scientists who are not medical graduates, pharmacists, dentists, etc.

I would further recommend that the committee on membership work out a plan by which the national, state and local organizations of these physical welfare activities may be affiliated with the American Medical Association and its component state and county societies.

Two weeks from to-day, July 11, the National Educational Association meets in San Francisco. The teachers of America have been powerful in the work of physical betterment. They are in a most advantageous position, for the seed of the truths of health once implanted in the child's mind grows with it and continues to bear fruit through life. This is well appreciated by religious workers who say: "Give me the child and the continuity of religion is safe."

I, therefore, recommend that the House of Delegates appoint a committee to bear to the National Educational Association the greetings of the American Medical Association, and express its appreciation of and thanks for the work they have done for the physical welfare of children and the hope that their future efforts may be materially increased. It would be desirable to have the committee arrange for an annual cooperative symposium at both of the national gatherings.

The Council on Health and Public Instruction should be placing health lecturers in every county in the union; also educational folders, leaflets, public press articles, etc., for the use of the local county committee for presentation to the public through these agencies.

When the people are educated and interested they will support and enforce every proper method for their betterment, and eventually we shall have as scientific an organization for the protection of the health of the people and their interests as we now have in the Department of Agriculture for the health of animals and plants. The movement will be irresistible. The physician is the natural flag-bearer; the people, the great beneficiary. The latter, however, will never sustain him in that position unless they have the utmost confidence in him. They will not enlist as his workers in his movements until he shows that he possesses and practices a standard of morality and integrity that is irreproachable.

IRREGULARITIES AMONG PHYSICIANS

Now, I have an unpleasant and most painful duty to perform, and that is to call this body's attention to the shortcomings of the medical profession—to the irregularities, immoralities and crimes that have crept into its practice. These have come to be recognized as public scandals. When public speakers attack us—when pamphlets derogatory to us receive general circulation—when newspapers repeatedly print exposés—there are now, through our years of internal protest and zealous remedial measures, too many in the secret for us to avoid open condemnation. For years within the confines of our organization, we have endeavored to suppress irregular advertising and exploitation. We have succeeded in producing penal enactments against abortion and infanticide, and have fairly well suppressed the practice. We have in many states abolished the quack advertiser and convicted a number of violators of these laws. If the exposure of the guilty physician had no other effect than to destroy the public confidence in that individual it would matter little to the profession in general, but it has a much deeper significance; it lessens confidence in all medical men and in all medical measures.

In assailing vice in every walk of life, there is a sense of humiliation in the admission of its presence, a shudder of horror at its exposure and a strong desire to minimize its malignant import. None of these, however, relieves us of our obligation to attack irregular, questionable and criminal practices with all the force and vigor of the manhood of this organization, with all the strength of the traditions of the profession, with all the impetus of altruism of medicine of all times, so as to preserve and sustain the purity and fidelity of the purpose of the profession in its transmission to our posterity. The medical profession should be the unquestioned forerunner of humanitarian undertakings. Our sacred calling should be exemplified in our acts, that each individual citizen may have every possible opportunity for the conservation of his health and the preservation of his life regardless of his ability to compensate the physician. There is a common, insidious and deadly parasite eating at the root of public medical confidence, and that is the practice of medical fee division, commission paying and the sale and purchase of patients. We should see to it that no man of our profession barters to the highest bidder in commission and fee divisions. He who offers or gives is morally as guilty as he who requests or receives, and no sophistries should be accepted in justification of this atrocious practice. The money changers of the profession must be driven out of the temple of Æsculapius as they were from the temple of religion.

The traffickers in human lives and infirmities must be stripped of their pseudo-ethical shield so that they may be known and recognized by the public. These, though comparatively few in number in some communities, are too great in all to be permitted to associate with the grand and noble, ever-ready and never-failing, unselfish and self-sacrificing body of general practitioners and specialists. A membership in this organization should be a certificate of manhood, of scientific attainment, of moral stamina and of loyalty to the principles of the Golden Rule, the basis of ethics of the medical profession. This united body must assume the responsibility for regulating the acts of its own members and if necessary request the legislative bodies of this great land to place on the statute books acts penalizing violations of professional trusts by doctors in and out of this organization.

This Association is called on by the public to relieve this situation. It relies on the justice and humanity of the cause. It relies on the power and response of your conscience when awakened. It relies on your love and devotion to the honorable traditions of your profession. It relies on your contempt for avarice at the expense of human suffering and human life. It relies on your love for and devotion to your fellow man. It relies on your integrity and sense of duty to your commonwealth, to your profession and to the people to exterminate these evil practices.

It is not sufficient for the profession of to-day to make great scientific advancement. It is our obligation to pass our untarnished traditional ethics in their highest sense to the succeeding generation, because it is only under the guidance of these basic principles of equity that the coming generation can accomplish the greatest good for the greatest number. Each generation must purchase by its deeds of valor, self-sacrifice, foresight and labor, security, blessings and advantages for the succeeding generations.

I recommend that the By-Laws be so changed as to make the Judicial Council a council in perpetual session with a salaried executive; that it hold meetings at least twice a year and as much oftener as is necessary; that it establish rules of procedure varying with the needs of different sections and different times; that it be empowered to appoint state subcommittees for special investigation; that it constitute the court of interpretation of all ethical relations—individual, organized and public; that it decide on and apply the proper remedy for the irregularities in practice; that it be invested with the right of suggestion where local societies are indifferent, unprofessional or unjust, and if this fails that it has the right of action against said society, subject to the approval of the House of Delegates; that it be constituted the court of appeal for any member of the medical profession who is denied membership in the American Medical Association through the refusal of his local society to accept him. After a fair and impartial trial this committee may make him a member of the American Medical Association. An expelled member of a local society may have the same rights.

The plan adopted in some states, whereby a member refused admission to his local county society may be accepted by any other county society in his state appears to be a good one for general adoption.

NATIONAL DEPARTMENT OF HEALTH

There is a deep-rooted public sentiment and a widespread movement throughout the land for the establishment of a national department of health. Senator Robert L. Owen, of Oklahoma, has been conspicuous in his advocacy of this measure. He introduced Senate Bill 6049 in the last Congress, and Senate Bill 1 in the present, for favoring the enlargement of the health functions of the national government. He has a keen insight and appreciation of the economic significance of health conservation. American medicine owes him a great debt for his labor and zeal in advancing this interest. We have already a fairly well-developed general medical service in the United States Public Health and Marine-Hospital Service. It has done excellent work in protecting the Pacific coast against plague, the Atlantic against cholera and the Gulf coast against yellow fever. It has made some admirable studies in its laboratories and added much to the value of the medical literature and to popular health education.

While it has developed greatly it has only kept apace with the great world movements of health. It has not been a leader. Even its most ardent supporters would not claim that it has attained the same degree of efficiency as our national bureaus which supervise the protection of agricultural interests.

If it be argued that public sentiment is not ripe for this movement, it only further proves the point which we make, i. e., that a way must be found to enlighten the people; they will then proclaim their rights and demand protection.

The character of the opposition to and the arguments advanced against this bill are clearly outlined in a personal letter which I recently received from Senator Owen.

UNITED STATES SENATE.

WASHINGTON, D. C., May 27, 1911.

Dr. J. B. Murphy, President-Elect,

American Medical Association.

My Dear Sir: Permit me to express my grateful appreciation of your invitation to address the Association at its next annual session in Los Angeles.

I deeply appreciate the kind manner in which you extend this invitation, and I had very greatly desired to have the opportunity of addressing what is perhaps the most useful and honorable association in the world, distinguished for learning, for intelligent service and for a noble spirit of self-sacrifice and altruism that marks the medical profession above all others.

I had greatly desired to address the Association in order to invite its more active sympathy and cooperation throughout the several states of the Union, in establishing a department of health, which I am endeavoring to do through Senate Bill 1.

The League of Medical Freedom, so-called, which I believe to be a league of those opposed to the Pure Food and Drugs Act, including some very honorable people who have been misled by these sinister forces, has established, I am told, a state league in nearly every state in the Union, with county and town organizations. I am advised that they are supplied with an abundant supply of money to carry on a wholesale campaign, advertising in a big way.

A few days ago I counted on one of the county papers of Oklahoma, on a single page, nineteen "patent-medicine" advertisements. These people are, of course, more or less potential.

The League of Medical Freedom denounces the American Medical Association as a "medical trust," charges it with being opposed to the freedom of the citizen in medical matters, and undertakes to stir up prejudice against the American Medical Association; charges the American Medical Association with being the author of Senate Bill 6049, to establish a Department of Health, which I, myself, drew and introduced during the last Congress without any consultation with the American Medical Association or any of its officials.

I regard it as of the greatest importance that the American Medical Association should exercise every energy possible to correct the false impressions spread broadcast by the so-called League of Medical Freedom. Every county in the United States should be organized and make a demand on the members of Congress representing such county and on the senators

representing such state to pass this bill establishing a department of health.

It is true that if a national department of health could, by bulletins, increase the general knowledge of how to prevent sickness, it would diminish the number of sick people appealing to the doctors of the country. It would diminish the doctor's clientage. It would take from him a part of his annual income, but it is a noble sacrifice which every doctor worthy of the name, be he allopath, homeopath, or of any other school, will gladly make for the general welfare. Everybody who knows the medical profession knows this is true, and the base charge made against the American Medical Association that it is a "medical trust" should not be allowed to go unchallenged or unrebuked.

Doubtless it may be true that in some states legislation may have been sought by members of the profession that gave offense to those who were not regarded as members of the so-called "regular" profession. Advantage has been taken of this feeling to stir up the hostility of those who do not practice the regular profession and arouse their hostility to a department of health on the foolish ground that a department of health, being desired by the American Medical Association, must be a bad thing for all practitioners who do not belong to the allopathic school. The truth is that there are many thousands of men who are teaching various forms of physical culture and of preventive medicine who do not belong to any school of any kind—such as Horace Fletcher and men of that class.

I earnestly trust that the American Medical Association will now enter on a militant campaign to promote the public health and to concentrate the federal health agencies in one well-directed, well-organized department which may serve as a light to the health departments and health societies of the cities, counties and states of the United States and serve a function as useful as that of the Department of Agriculture, which has shown itself to be invaluable by disseminating information of a high character.

The new bill introduced by me to establish a department of health (Senate Bill 1) is an improvement on the bill which I myself drew a year ago, and has been modified to meet, as far as possible, some of the criticisms which were urged against the Senate Bill 6049.

The new measure contains express provision that the department officers shall not exercise any activity properly belonging to the states, without invitation from the proper state authorities, shall not enter any private house without permission of the inmates, and shall not discriminate in favor of any school or system of medicine.

The plain truth is that nine-tenths of the activities of a department of health would be devoted to race conservation, and the prevention of disease and death by proper quarantine, by authoritative information on the prevention of sickness put in the hands of the people, so that the people of the United States might be energized in protecting themselves from the typhoid fly, the malarial mosquito, the hookworm parasite, the tubercle bacillus, etc.

All learned physicians approve these things, and from the medical profession I have received the chief support in the effort to establish this department. The medical profession has been shamefully misrepresented, as I have said, as desirous of establishing a medical trust, when, in reality, if this department of health should be established, its first important service would be in reducing substantially the sickness of men, women and children, and thus diminishing the clientage of the practitioner, whose activities, unfortunately are so largely of necessity confined to restoring those who have made themselves sick by ignoring the laws of health.

I wish there could be some way in which the medical profession could be properly compensated for instructing people how to keep well and to become physically better. Perhaps, under the impulse of a department of health, the people will realize the importance, more and more, of authoritative instruction in the laws governing the preservation of health and of physical well-being, so that there might grow up in this country a new system of retaining medical men, charged expressly with the duty of instructing their clientage in the art of "how not to get sick." It seems to me that this might be a topic worthy of consideration and discussion by the American Medical Association.

There has been some genuine opposition to a department of health by some men, earnest and sincere, engaged in teaching the laws of health, and who have the following creed: "Men who are taught to live right do not need medicine; men who do not live right cannot be cured by medicine."

I believe the value of materia medica has been greatly exaggerated, and that there is much force in the creed which I have quoted to express the idea of those who are teaching methods of right living.

Very many thousands of physicians are engaged in this work of teaching right living, but the medical profession itself has so often been hypnotized by the Latin prescriptions of materia medica and the unavoidable recoveries (due to the providence of God), that they themselves as individuals frequently illustrate the violation of the soundest laws of right living, indulging to excess in tobacco, alcohol, food and in other ways, which prevent medical men from being high-class physical athletes and perfect specimens of physical life.

I wish you would do me the honor to say to the members of the American Medical Association that the first duty of a member of that great and honorable body is to present himself to his clientage as a model man, illustrating the glorious effects of obedience to the laws of right living, and that he offer himself as an exhibit worthy of imitation by those to whom he ventures to give advice concerning the most vital of all human possessions—good health and life.

I send the American Medical Association the most cordial greetings, with assurance of my earnest sympathy and admiration for that great body and its patriotic and self-sacrificing membership.

Yours faithfully, ROBERT L. OWEN.

The American Medical Association should, at this meeting, formally and strongly endorse the Owen bill. I respectfully recommend that the House of Delegates instruct the Board of Trustees and urge the Editor of THE JOURNAL to use all possible effort in advancing this movement. Furthermore, the Council on Health and Public Instruction should see to it that all of the great physical welfare organizations of this country speak their minds freely and emphatically on this matter. This Association has in the past year agitated and worked for this department without immediate results, but we recognize that in these movements there is always a stage of inertia in the cure of which the factor —time—cannot be eliminated.

SCIENTIFIC ACHIEVEMENTS SINCE LAST MEETING

While there has been no epoch-making discovery since our last meeting, great practical advancements have been made. The treatment of spirochete infections has been greatly advanced, though not mastered. The efficiency of vaccination in the prevention of typhoid fever has been thoroughly demonstrated in the encampment of the American troops at San Antonio. Here 18,000 men were encamped in a warm climate in an unfavorable season and under unfavorable conditions, and not a single case of typhoid originated in a soldier or a camp employee who had previously received the prophylactic vaccination. The prophylactic vaccination for measles has proved very effective. Vaccine treatment of disease as a whole has materially advanced in the last year. We are establishing a definite dosage, acquiring a knowledge of the best interval, and becoming familiar with the serviceable combination of vaccines.

Not infrequently the apparently fruitless years from the standpoint of the public are those in which the best work is done and from which the most potent results eventually flow. There is a steady onward medical movement in the protection given the people against disease.

Living in the home city of THE JOURNAL, I have had an opportunity to attend the meetings of the Board of Trustees and become acquainted with the workings of the various councils and standing committees—pharmacy, chemistry, public instruction and hygiene, blindness, etc.—and to see the splendid new building completed and the offices and machinery installed.

I trust that those of you who are not on the Board of Trustees or in the House of Delegates or do not even attend the annual meeting will carefully read the excellent detailed report of the Editor and General Man-

ager, Dr. Simmons, made to the Board under date of Feb. 3, 1911; that you will interest yourselves in the ably edited synopsis of the work accomplished by the Council on Medical Education; that you will analyze and take educational advantage of the reports of the Council on Pharmacy and Chemistry; and that you will scrutinize the outlined plan for the future work of the Council on Health and Public Instruction. These reports are too voluminous to permit of an intelligent resumé here and of too great import to be overlooked by a single member of the Association. A study of these will enlighten you on the scope, force and stability of this mighty organization and impress on you the arduous labors imposed on the Board of Trustees, the Editor and the councils and committees, in conducting this work.

In conclusion I would say that the claim that the profession is overcrowded is not founded on facts. From personal observation of hospital and private practice for a third of a century, I would say that less than 40 per cent. of the people requiring operations are given surgical opportunities for relief. From a medical and surgical experience combined, and through information received from eminent medical men, I would say that not exceeding 60 per cent. of the acute and chronic cases are correctly and timely diagnosed; that procrastination is the curse of medical diagnosis and medical action, entailing an invalidism and mortality. The people foster this more than they do any other shortcoming in medicine.

There is not a sufficient number of competent medical men to treat all of the medical cases, nor of surgeons to do all of the operations, of obstetricians to attend all of the confinements, nor of specialists to meet all of the special demands. What *we* need is a lesser generalization of patients in diagnosis and treatment and a closer individualization of the special conditions and demands. What the *patient* needs is relief of his symptoms. If this were done and efficiently done, every doctor in this great land would be overworked and self-satisfaction in the practice of medicine would be a rarity.

Competency is attained and maintained only by zeal, indefatigable labor and continued efforts in self education. The responsibilities of his profession rest on the individual man. If he shrinks from its weight the burden grows doubly heavy. If he "short-cuts" for success he sinks into the mire of dishonesty and dishonor. If he carries the weight with an erect figure, abiding integrity and a strong heart, it rides like a bubble.

MEDICAL COMPETITION

The physician or surgeon is not in competition with his fellow practitioner at all, but is in competition with the average standard of the medical qualification of his time. This standard is the line dividing mediocrity and incompetency of varying degrees from knowledge and efficiency. He who keeps above the standard desires companionship. Therefore, if we elevate the ethical and educational average, we increase the brotherhood of the profession and enhance the percentage of efficiency to the public. The effect of capital and labor organization has been to lessen individual exertion and reduce men to a common or mediocre level—their decadence is inevitable. The ideal of medicine, on the contrary, must be the stimulation of individual exertion to the highest degree and the establishment of a standard, the attainment of which should be the one great desire of every member of our profession, each to assist the other in his upward progress. Advancement is retarded by the failure of the individual to utilize time and avail himself of opportunity. We are all spendthrifts of time; all overlook great opportunities. Many are ruminants on their imaginary disadvantages in the contest: these never become producers. The demand of the times is that we level every opposition and make smooth the way for general progress, enlightenment, education and the higher ethical obligations. The individual is responsible for his own position and to a limited but positive degree for that of his fellow practitioner. When given a diploma from a medical school or a license to practice, we are all supposed to be equal. But no insignia makes men equal in medicine more than in any other line of human endeavor. By their superior intellectual qualifications, their fidelity to purpose and above all their indefatigable labor the few become leaders. American progress has been made the admiration of the world. The American medical profession has sustained the statements which Emerson made for American scholars, in his Cambridge address, in 1837: "We walk on our own foundation, we work with our home-trained hands; we think with our free-bred courageous brains, and over all we execute with a power of art, admired and imitated by the world."

32 North State Street.

RACE AND ALCOHOLIC INSANITY

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NEW YORK

The population of New York City, containing, as it does, such unusual aggregations of people from all parts of the world, furnishes a rare opportunity for comparative studies in race psychopathology. The conditions of an interesting experiment are practically fulfilled in that we find a number of races of pure blood living side by side in large colonies in a uniform, general environment. While this unique situation provides the alienist with material for making observations of great scientific interest, it is also a matter of practical importance for social workers, educators and physicians generally to become acquainted with any data which show the existence of special racial tendencies to disease, to immorality, or to excesses of various kinds; of particular interest are any facts relating to the extent of inebriety or the manifest pathologic effects of alcohol among these various elements which are streaming into our population.

At the Manhattan State Hospital, which receives patients exclusively from the City of New York, we have been strongly impressed with what appears to be a relation between racial types and certain forms of mental disease. We have noticed particularly that in some races alcoholic insanity was remarkably frequent, while in others it was extremely rare. This paper gives the results of an inquiry regarding the relative frequency of alcoholic insanity among the larger racial groups which go to make up the admissions to the hospital.

It is only within the past few years that our knowledge concerning the toxic psychoses has progressed sufficiently far to enable us to make anything like an accurate estimate regarding the frequency with which alcoholic insanity occurs in a community. In the reports issued by the New York State Hospitals, prior to six years ago, "alcoholic insanity" did not even appear in the statistical tables as a recognized form of mental disorder, and no

attempt was made to differentiate the alcoholic psychoses from the old groups of mania, melancholia, paranoia, dementia, etc. Alcohol, of course, plays an etiologic rôle and often an important one in many psychoses other than the alcoholic insanities proper, but at present we include in the alcoholic group only the specific alcoholic psychoses — those mental disturbances which arise in chronic drinkers and present a characteristic symptom-complex. This better circumscription of the alcoholic group permits us now to make such comparisons as are here presented with much more accuracy than was formerly possible.[1]

The first analysis covers the following racial divisions which are shown in Table 1: The Irish group is composed of natives of Ireland whose ancestors were Irish. In a similar manner the native Germans and Italians make each a group. The Negroes and Jews form separate groups, without regard, however, to country of birth or length of time in America. For purposes of comparison I have added a group made up of individuals whose parents were born in the United States. This American group cannot, of course, be viewed as representative of any particular strain of blood or ethnologic division, but it is of interest to note how our native stock compares with the other racial groups studied. In a final group we have a remaining heterogeneous collection, containing representatives of almost every race in the world, but in numbers as yet too small to allow any safe deductions.

TABLE 1.—ANALYSIS OF 1,762 CASES OF BOTH SEXES, SHOWING PERCENTAGE OF ALCOHOLIC INSANITY IN THE DIFFERENT RACES AND NATIONALITIES

	Irish.	German.	Italian.	Negro.	Jewish.	U. S.*	Other Races.
Number admitted..	336	193	123	90	455	222	342
Per cent. alcoholic insanity	20	9	5	4	0.6	5	10

* Children of native-born parents.

Table 1 is based on a review of 1,762 cases, in which the patients were admitted to the hospital suffering from various forms of mental disorder. The first line of figures gives the number of persons of each race included among these 1,762 cases. The second line of figures shows the percentage of alcoholic insanity found among each of these racial divisions.

The most striking contrast is furnished by comparing the figures for the Irish and the Jews. Twenty per cent. of the 336 Irish people admitted were suffering from an alcoholic psychosis, while only 0.6 per cent. of the 455 Jews admitted were subjects of alcoholic insanity. Next to the Irish come the Germans, with 9 per cent. of alcoholic insanity, while the Italians showed only 5 per cent., and the Negroes the relatively low figure of 4 per cent. In the American group there was 5 per cent. of alcoholic insanity. All the remaining races lumped together totaled 342 persons and showed 10 per cent. of alcoholic insanity, a relatively high figure, but still far below that attained by the Irish.

TABLE 2.—OCCURRENCE OF ALCOHOLIC INSANITY AMONG MEN OF VARIOUS RACES AND NATIONALITIES

	Irish.	German.	Negro.	Italian.	Jewish.	U. S.*	Other Races.
Number admitted..	127	110	42	75	249	118	183
Per cent. alcoholic insanity	30	12	9	8	1.2	5	15

* Children of native-born parents.

Now when we tabulate separately the men and women, we obtain figures even more striking. Among the men, Table 2, we find the Irish with 30 per cent. of alcoholic insanity—which is two and a half times greater than that found in the next highest group, the Germans. The Negroes and Italians show approximately the same percentage, while the Jewish figure is 1.2 per cent. (this figure represents three cases of alcoholic insanity, the total number found among the Hebrews). The American group shows 5 per cent. In the remaining composite group the figure 15 per cent. is again high.

TABLE 3.—THE INCIDENCE OF ALCOHOLIC INSANITY IN WOMEN

	Irish.	German.	Negro.	Italian.	Jewish.	U. S.*	Other Races.
Number admitted..	209	83	48	48	206	104	159
Per cent. alcoholic insanity	15	3	0	0	0	5	3

* Children of native-born parents.

The figures for the women, shown in Table 3, I regard as particularly interesting. Here the overwhelming frequency of alcoholic insanity among Irish women stands out clearly, as 15 per cent. of the Irish women admitted were suffering with alcoholic insanity. The next highest group is the American, with 5 per cent., while the German women are third with 3 per cent. Not a single case of alcoholic insanity was found among the Negro, Italian or Jewish women entering the hospital.

TABLE 4.—COMPARISON OF RACIAL STOCKS, BOTH SEXES

	Irish.	German.	Negro.	Italian.	Jewish.	U. S.*	Other Races.
Number admitted..	560	291	90	134	455	222	375
Per cent. alcoholic insanity	19	10	4	4	0.6	5	10

* Children of native-born parents.

In the last tabulation, Table 4, a comparison is made on a different basis. An attempt is here made to compare racial stocks and to disregard place of birth. Under the Irish, for instance, we include all the natives of Ireland and the first generation of children born in the United States of Irish parents. In a similar way the German and Italian groups are formed. As in the former tables, the Negroes and Jews are kept apart and form each a group, without regard to country of birth or length of time in America. Also, as in the previous tables, I have restricted the American group so as to comprise only those individuals whose parents were born in the United States. This table covers 2,127 cases, and the percentages obtained from this comparison are very similar to those shown in the first table. The Irish and their descendants rank highest, then follow the Germans, Americans, Negroes, Italians and Jews in the order named. This last table seems to show pretty definitely that about the same disposition to alcoholic insanity exists in the first generation of children born in the United States as in the foreign-born parents.

The figures for the Irish race demonstrate in a most convincing manner the tremendous rôle played by alcohol in the mental disturbances of these people. Unfortunately, we have no reliable data on the extent of alcoholic insanity among the Irish in their native land and natural environment. Regrettable differences in nomenclature and confusion as to what psychoses are to be designated as alcoholic, prevent our obtaining from Irish physicians any figures which might be compared with ours. The Irish working classes of our large cities, are, I believe, rather generally regarded as intemperate people and great whisky drinkers. One should remark that the Irish also, to a large extent, control the liquor traffic, or at least are among the chief dispensers of alcoholic drinks. Occupation is, however, probably not an important predisposing factor, as the high percentage of alcoholic insanity among the women speaks against this.

1. Our figures do not include cases of delirium tremens, which are, of course, true psychoses, but which are practically all cared for in the alcoholic division of Bellevue Hospital, thus rendering unnecessary their commitment to a state hospital.

The amazing prevalence of alcoholic insanity among Irish women must be viewed as a serious menace to the mental and physical health of these people and their descendants. I am inclined to believe that our figures mean that the Irish constitute the most intemperate element in our population and that their preference is for alcohol in the form of whisky. The question as to whether they are, as a race, unusually susceptible to alcohol, remains unanswered.

The Germans are evidently less intemperate than the Irish and drink more beer, which alone is far less dangerous to the mental health than the stronger alcoholic beverages.

The Italians, certainly in their native country, are generally regarded as a temperate people, with a preference for alcohol in the form of light wines. The low percentage of alcoholic insanity among those who come to this country is striking.

The low percentage of alcoholic insanity found among the Negroes was a surprise to me. I think that it is commonly believed that immorality and alcoholic excesses are prevalent among the negro dwellers in cities, especially the large communities of the North. That sexual immorality is common, is shown by the fact that among the admissions to the hospital the Negroes stand higher than any other race in general paresis, a disease of syphilitic origin. If alcoholism exists extensively in the colored race, it has not yet manifested itself in mental diseases of alcoholic origin.

The infrequency of alcoholic insanity among Jews has been noted by observers in various countries, even in certain localities where alcohol is taken excessively by these people. The Hebrews that emigrate to America are, I believe, as a class, remarkably temperate. On the other hand, I find that a good deal of alcoholism exists among American-born Jews, but as yet they show no more tendency to develop alcoholic insanity than did their more temperate ancestors.

The results of the study demonstrate that some races, particularly the Irish, are remarkably liable to develop alcoholic insanity, while others, notably the Jews, are almost free from mental disease due directly to alcohol. The question naturally arises: Are some races unusually alcoholic or are they merely more sensitive than others to the poisoning effects of this agent, and, therefore, more prone to break down with alcoholic insanity?

Besides the form and amount of alcohol consumed and the power of resistance possessed against its injurious effects, other important factors undoubtedly come into play, e. g., occupation, social customs, home environment, religious influences, etc., It is, therefore, evident that the causes for this apparent susceptibility of one race and relative immunity of another depend on a number of factors of rather complex nature and about which we should seek more knowledge. In the meantime the indications are pretty definite as to what elements of the community stand most in need of educational and prophylactic measures.

Bacterial Lineage.—"There could hardly be a better example of the scientific spirit than the application of the methods of biometry to those excessively minute organisms, the bacteria. Experiments in this relation marked the beginning of a new era in bacteriologic classification and nomenclature. There have been applied the methods used by anthropologists and students of variations and heredity to the definition of the species of bacteria. The results are, of course, technical in their nature, . . . but they have a broad general interest."—*Scientific American*, June 3, 1911.

CHRONIC PANCREATITIS IN ASSOCIATION WITH GALL-STONE DISEASE*

JOHN B. DEAVER, M.D., LL.D.

PHILADELPHIA

It is now well known, particularly among surgeons, that in close association of the pancreas and its ducts with the common bile-duct we have an arrangement which is responsible for many cases of pancreatic disease. Recently I have collected the reports of seventy-three of my own cases of chronic pancreatitis in which I have verified the diagnosis at operation. Of these, forty-seven (65 per cent.) showed demonstrable disease of the gall-bladder or biliary ducts. Thirty-five, or approximately one-half, had gall-stones at the time of operation. Mayo found gall-stones in 81 per cent. of his cases of pancreatitis and Robson asserts that pancreatitis is associated with stones in the common bile-duct in about 60 per cent. of all cases. From these and similar observations it has become evident, first, that pancreatic disease is far more common than has hitherto been supposed, and, secondly, that a potent cause of pancreatic inflammation is to be found in what Mayo has aptly termed the "unfortunate association of terminal facilities" of the liver and the pancreas.

The usual descriptions of the anatomy of the pancreas are incomplete in that they do not sufficiently recognize the remarkable variations in the anatomy of the organ. From the standpoints of pathology and surgery we are concerned not so much with the variability in size and form as with the variations in the ducts which drain the organ and in the influence which the usual as well as the anomalous modes of duct-formation exert on ascending infection of the pancreatic tissue and the possibilities of drainage of the normal and pathologic fluids and exudates in conditions of inflammation or obstruction. The more recent studies of Schirmer and of Opie have greatly added to our knowledge of the anatomy of the ducts. Opie, in a series of one hundred cases studied with reference to this point, found both the duct of Wirsung and that of Santorini constantly present. In ninety cases the two ducts had an anastomotic connection. In the remaining ten the ducts were independent and with reference to their size were equally divided in number, in five instances the duct of Wirsung being larger, in the remaining five the duct of Santorini predominating in size.

In the ninety cases in which the ducts were joined within the substance of the gland, the duct of Wirsung was the larger in eighty-four cases, while the duct of Santorini was greater in only six cases.

The duct of Wirsung was found patent in every case. The duct of Santorini was not patent in twenty-one cases, while in more than half of all individuals it was either completely occluded or so narrow as to be incapable of assuming the function of the larger duct when occluded.

In considerably more than one-half the specimens both ducts were patent and the duct of Wirsung which unites with the duct of Santorini was larger than the latter. The usual description of the arrangement of the ducts, therefore, holds true in the majority of cases, but there is still a considerable proportion in which an anomalous arrangement may present a more or less favorable mechanism for the production and maintenance of pancreatic inflammation.

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* Read before the Hospital Graduates' Club of New York City, April 27, 1911.

The relation of the choledochus with the pancreas and its ducts is also variable and that variability may be the cause of symptoms which differ in kind and severity. Helly has shown that in approximately two-thirds of all cases the common bile-duct penetrates the head of the pancreas and is completely surrounded by pancreatic tissue. This gives us the well-known explanation of the production of jaundice by swelling of the head of the pancreas. Well-founded observation has now shown that at least a percentage of the cases of so-called catarrhal jaundice are thus produced by occlusion of the duct by the enveloping pancreatic tissue swollen as a result of some inflammatory process.

The origin in embryo of the common duct in close contact with the ventral pancreatic outgrowth is shown in adult life by the close connection of the choledochus and the duct of Wirsung at their terminations. They penetrate the coats of the duodenum side by side and pass obliquely through the wall to end in the majority of instances in the diverticulum of Vater which discharges by a single opening into the intestine. Rarely they open separately. It is evident, therefore, that a gall-stone passing down the choledochus must produce more or less disturbance of the duct of Wirsung when it lies in immediate relation to it. This may occur as more or less complete occlusion by the stone pressing directly on the pancreatic duct through the walls of the common duct, or by the extension of the inflammation caused by the passage of the stone to the pancreatic duct and adjacent tissue. A rarer mode of disturbance is exemplified by Opie's classical case in which the papilla of Vater was closed by a small stone, thus causing the retrojection of bile directly into the pancreatic duct which set up a fulminating and fatal pancreatitis.

At times calculi may be present in the common duct in close proximity to the pancreas for a considerable period. It is practically inevitable in such cases that the pancreas should be involved in the resulting inflammation.

There are three points at which such chronic lodgement is apt to occur. The first is at the point where the common duct plunges into the head of the pancreas. This is effective in only about two-thirds of all individuals as previously indicated from the anatomy. The second marked constriction is at the point where the duct penetrates the wall of the intestine, and the last and most marked obstacle is the narrow outlet of the papilla of Vater.

It is not necessary that stones be present in order to have infection of the pancreas or its ducts from the biliary apparatus. In twelve of my cases no stones were found, nor did the history indicate that any had been passed. There was present, however, a more or less marked non-calculous cholecystitis and cholangitis.

Doubtless it is unfair to assert in every instance in which biliary and pancreatic disease is found coexistent that the pancreatic inflammation is always transmitted from the biliary tract. The pancreas can be infected alone. In twenty-two cases of chronic pancreatitis I have found the biliary tract uninvolved at the time of operation. It is stretching the facts to assume that in these cases the pancreatic disease had been initiated by cholangitis which later disappeared. While this is possible, there is one important observation which seems to cast doubt on it. This is the fact that in simple chronic pancreatitis unaccompanied by gall-stones the incidence according to sex is reversed. In thirty-eight such cases elsewhere reported by me, there were twenty-two males and sixteen females. That this is not a chance finding is corroborated by Opie and by Böhm, both of whom observed the same preponderance among males. In view of the more frequent affection of the biliary passages among females this lack of parallelism further strengthens our belief that there exist certain cases of pancreatitis which are primary and in no way to be attributed to an antecedent inflammation of the bile-passages. If Desjardins is right in his belief that the same infection arising in the intestine and traveling up the bile and pancreatic ducts will in the former produce a stone-forming catarrh and in the pancreas will cause a chronic interstitial inflammation, it would seem to follow that the pancreas is more susceptible to ascending inflammation than are the bile-passages, and this would further square our finding with the fact that duodenal catarrh is more common in the male than in the female sex. We have long ago concluded that by far the greatest number of cases of inflammation of the bile-passages are hematogenous in origin, the bile being infected chiefly by the bacteria carried to the liver through the portal vein and by the liver excreted into the bile, which, so far from being strongly antiseptic in action, is now known to be an excellent culture medium for many bacteria. The pancreas is provided with no such circulatory apparatus as the liver and is thus guarded from infectious material carried from the intestinal tract, except through the roundabout circuit of the systemic circulation.

Primary uncomplicated pancreatitis is, therefore, most probably ascending in origin. This statement refers, of course, not to those infections which are clearly systemic, such as the characteristic syphilitic pancreatitis, or to that form of interacinar inflammation which affects the whole gland and, while its cause is not definitely known, seems to be more closely related to systemic causes. It refers only to those cases in which the inflammation is confined chiefly to that part of the pancreas which is in close proximity to the duodenum, producing a hard, nodular enlarged head of the organ without disease of the biliary tract.

While admitting, therefore, the existence of a primary pancreatitis probably of ascending origin, it is nevertheless true that the majority of inflammations of this organ owe their existence to previous cholecystitis and cholelithiasis; until the common duct becomes diseased it is rare for the pancreas to be greatly affected. The close relation of pancreatic inflammation to disease of the common duct is shown also in the fact that it is relatively rare for the entire pancreas to show chronic changes. The head is mainly and often exclusively involved, and particularly that portion of the head which lies in the triangle formed by the duodenum as a base and the two ducts as they converge from their outlets to the point of anastomosis within the gland. This is the so-called triangle of pancreatic inflammation.

That there is a more or less definite relation of the anatomical peculiarities of the ducts to the ease of infection and the severity of its manifestations is undoubted, but as yet we are able to bring but few clinical observations to illustrate the point. It must be true that the larger the accessory duct and the more capable it is of carrying on the excretory function of the gland the less is the liability of serious damage by gall-stones and their complications. It appears unfortunate that this arrangement occurs in only a minority of the cases.

The symptomatology of the milder grades of pancreatic disease is not yet sufficiently definite to enable one to recognize it in all instances. It is, moreover, so similar in many respects to that of biliary infection and cholelithiasis that it may be difficult or impossible to

determine before operation whether or not the pancreas is affected. Chronic pancreatitis alone may exactly simulate the well-known picture of gall-stone disease. Even the distinctive Charcot's syndrome of hepatic intermittent fever may be produced by chronic pancreatitis.

One recent instance which I have not included in the statistical part of this paper may be outlined here:

History.—Mrs. E. M., aged 52, was admitted to the Hospital of the University of Pennsylvania complaining of severe recurring pains in the right epigastrium. About five years previous to admission she had several attacks of typical gall-stone colic for which she was operated on in Baltimore. She was told that gall-stones were found and a biliary fistula was made which drained for five weeks. Within a few weeks after the operation she again began to have attacks of pain in the region of the scar which were at times associated with vomiting, jaundice, chills and fever. She was told that she had malaria. The paroxysms of pain were so severe that she would writhe in agony on the floor and required large doses of morphin for relief. There was no periodicity observed in the attacks which gradually became more frequent. The vomitus was small in quantity, biliary in character, never blood-tinged. The bowels were fairly regular and the movements usually light in color. Her complexion was chronically sallow, deepening to saffron with attacks. In her previous history she had had several attacks of malaria, many years ago, and typhoid fever at 16 years of age. Seventeen years previous to admission to the hospital she had had what the doctors called "bowel consumption," characterized by an intractable diarrhea lasting several years, which reduced her weight to 69 pounds. Her best weight was 115 pounds.

Examination.—On admission she was emaciated, weak and the skin and conjunctivæ showed a slight icteric tinge. The next night she had an attack of pain with nausea, followed by distinct deepening of the jaundice. The epigastrium was so excessively sensitive that she would not permit deep palpation. Muscle spasm was present in the epigastrium. The lower abdomen was soft. The urine showed a faint trace of albumin and was positive for urobilin. The hemoglobin was 60 per cent. and the leukocytes 2,331 per c.mm. With the abdominal walls relaxed by the anesthetic before operation there was easily felt in the midepigastrium a firm rounded mass, which was freely movable in all directions through a radius of about 2½ inches. From the physical character of this mass the possibility of pyloric carcinoma was entertained.

Operation.—On opening the abdomen, the movable mass proved to be the greatly indurated and nodular head of the pancreas. The common duct, which was considerably dilated, was opened and together with the hepatic ducts was explored for stones and found free. The gall-bladder was opened and found to contain only thickened tarry bile. Drainage was instituted from both the gall-bladder and the common duct.

Postoperative History.—The drainage, which was scanty for the first few days, gradually became more profuse and normal in color. Convalescence was uneventful. There were no further attacks. Icterus disappeared and the patient began to gain in weight even before any bile was discharged into the bowel. She left the hospital at the end of a month with a small biliary fistula almost closed. Dr. George Stump of Perryville, Md., who kindly referred this patient to me, tells me the patient is well, eating heartily and taking on flesh.

The chief points of interest in the case are: (1) the onset shortly after operation for gall-stones, or perhaps we should say the persistence of pancreatitis after operation, for it is more than likely that the pancreatitis began during the attacks of cholangitis and gall-stone colic preceding operation; (2) the simulation of the symptoms of stone in the common duct by simple pancreatitis, and (3) the very satisfactory effect of hepatic drainage on the disease.

Pancreatitis is a disease of adults, the average age in my cases being about 44 years, and the extremes, 23 and 65 years. The predisposing causes are chiefly the same as those of gall-stone disease and the early history is that so well summarized by Moynihan in his address on "The Inaugural Symptoms of Gall-Stones." It would be interesting and valuable to determine with exactness the onset of pancreatitis as a complicating factor in gall-stone disease, but this is a practical impossibility. We may have a presumptive diagnosis of pancreatitis which will prove to be correct in the majority of instances when the symptoms point unmistakably to severe or repeated involvement of the common duct. It is quite likely that we frequently ascribe symptoms to disease of the biliary tract alone which are in reality the result of coexisting disturbance of the pancreas. It is but a few years since the pancreas was entirely neglected in the examination of the contents of the upper abdomen, and the surgeon who discovered disease of the bile-passages was quite content to explain all the symptoms on this basis. Now, when we make palpation of the pancreas a routine part of upper abdominal exploration, it is not uncommon to find evidence of disease that must certainly have been accompanied by clinical signs. The task of separating signs pancreatic from signs hepatic, cholecystitic or duodenal is not an easy one.

The recognition of chronic pancreatitis depends on three separate branches of inquiry: (1) the clinical history; (2) the physical examination; (3) the special tests for disturbed pancreatic function.

In the simple uncomplicated forms, chronic pancreatitis usually begins with disturbance of digestion which may take the form of discomfort, flatulence or pain after eating. If there are any particular articles of diet which are not well borne they are apt to belong to the carbohydrate class. The relation of pain or discomfort to the taking of food is an inconstant one. Periodicity of attacks is not marked as in duodenal ulcers. Subjectively the pain is not characteristic, nor are its location or paths of radiation distinctive. Nausea and vomiting usually occur at some time in the disease, but usually with the more acute exacerbations and at irregular intervals. Jaundice is present or has been noted previously in about two-thirds of the cases. Constipation is the rule. It is seen at once that among these symptoms there is none that may not apply as well to biliary disease as to pancreatitis. Hence the difficulty of surmising to which condition given symptoms are due.

The foregoing statements I have based on a careful analysis of the symptoms in sixty cases of chronic pancreatitis, half of which were complicated by gall-stones, while the remainder were not associated with stones. A partial summary follows:

TABLE OF PANCREATITIS FINDINGS

	Thirty Cases Complicated by Stones	Thirty Cases Uncomplicated
Male	7	17
Female	23	13
Acute severe pain	17	17
Jaundice	21	10
Vomiting	16	17
Belching	12	9
Previous indigestion		14
Recurrent attacks	29	21
Indigestion between attacks	8	9
Colicky pain	8	9
Seat of Pain:		
Epigastrium	20	15
Right costal margin	16	12
Left costal margin	3	1
General abdominal		1
Lumbar	1	2
Referred Pain:		
Right shoulder	12	8
Left shoulder	4	2
Back	14	8
Tenderness:		
Right costal margin	24	18
Left costal margin	3	4
Epigastrium	10	11
Gastric Contents, Free HCL:		
Normal	8	2
Subnormal	8	13
Above normal	1	1

In the diagnosis of chronic pancreatitis the physical examination is not of great service. Occasionally in thin subjects under favorable conditions, the pancreas may be felt lying transversely across the midepigastrium. The greatly swollen head of the organ may at times be palpated and during exacerbations it is exquisitely tender. Rigidity of the overlying muscles usually prevents detection of a mass when inflammation is marked. A sense of resistance or indefinable mass in this situation is sometimes helpful. A point which has interested me is the mobility of the organ. We are apt to suppose that the pancreas is quite securely fixed in its retroperitoneal situation. It may, however, possess a considerable degree of mobility, especially in emaciated patients, when the loose areolar tissue behind the peritoneum has been stripped of its adipose packing. In such circumstances a palpable pancreas may be moved about at will much like a pyloric tumor. This is true only of inflammatory enlargements. Malignant disease fixes the organ immovably in position by infiltration of the surrounding structures.

Simple tenderness in the epigastrium is a very misleading sign. Unless it is well marked but little attention should be paid to it. When it is clearly pathologic it may be due to other causes than pancreatitis. In the above table it was noted in about one-third of the cases, and when clearly localized to the region of the head of the pancreas it may be given weight as a confirmatory sign.

The gastric analysis in my experience has usually shown a subnormal acidity in simple pancreatitis while in the presence of stones the acid content is more likely to be normal or higher.

In the absence of signs and symptoms by which we may establish the existence of coexistent disease of the pancreas we have turned to various devices intended to demonstrate whether or not the function of the organ is disturbed.

It is well known that carbohydrate metabolism is closely dependent on the pancreas. Starch digestion is chiefly accomplished by the amylopsin of the pancreatic secretion, while all carbohydrates after their absorption as sugar depend for their utilization within the body on the presence and functional activity of the pancreas. Furthermore, we have reason to believe that it is the islands of Langerhans which are invested with this special function. Evidently disease of the pancreas of sufficient degree to disturb these bodies should give rise to an alteration in the behavior of the body to carbohydrates.

In two of my cases (7 per cent.) there was slight but persistent glycosuria. I have seen still other instances in which glycosuria was demonstrated during exacerbations of pancreatitis, disappearing during the interval.

The assimilation limit for carbohydrates may be lowered in still other cases which, under ordinary diet, do not show glycosuria. That this symptom is not more commonly associated with pancreatitis is fortunate and due chiefly to two facts. First, a small amount of normal pancreatic tissue with its central islands is capable of maintaining the internal carbohydrate metabolism. The body or tail of the organ may be found quite normal even when there is marked chronic inflammation of the head. Secondly, Opie has shown that there are two chief varieties of chronic pancreatitis, the interlobular and the interacinar. In the former type the sclerosis affects almost exclusively the interlobular septa and the central portion of the lobules are protected for a long time. Thus the islands of Langerhans are saved from injury. In the interacinar type the fibrous tissue invades the lobules themselves and may early attack the islands, causing atrophy or hyaline degeneration. It is the interlobular type, which is less dangerous for the islands, that is most likely to follow obstruction to the pancreatic duct and such inflammations as result from gall-stones and biliary infection.

That there is a danger of diabetes even here is shown by my observations and those of other workers in this field. The demonstration of sugar in the urine in connection with symptoms of an organic lesion in the upper abdomen give conclusive evidence for the belief that the pancreas is diseased.

A more complicated test which appears to depend on similar facts is that devised by Cammidge. This consists in the demonstration in the urine of certain crystals which are typical in form and solubility and are believed to be derivatives of a pentose. While I have not been so fortunate as the author of the test in obtaining positive reactions in chronic pancreatitis I have found it constantly present in acute pancreatitis and in the more severe exacerbations of chronic pancreatitis.

In this series the reaction was positive seven times (25 per cent.), negative twenty-one (75 per cent.).

Examination of the feces is important. The typical, large, fatty, diarrheal stools to which the term steatorrhea is applied, is very strong evidence of insufficient pancreatic function. This typical stool, however, is present only in late and extensive disease of the organ. I have already stated that constipation is the rule. Undigested muscle fibers (azotorrhea), if marked, possess some significance, though care must be exercised in interpreting this finding. The presence of an excess of neutral fat or of both neutral and split fats when stercobilin can be shown chemically to be present in the feces is a point in favor of deficient pancreatic secretion.

It is well to note that clay-colored stools do not mean absence of bile, since a large amount of unabsorbed fat and fatty acids will give the same appearance. If stercobilin can be demonstrated chemically it will prove that bile is being discharged into the intestine and that the chief source of the digestive disturbance is not the liver or its ducts, but the pancreas.

I have not made use of the various tests for demonstrating pancreatic ferments in the gastric and duodenal contents and feces. The ferments act in such incredibly small amounts that until pancreatic disease is very marked it seems to me that the ferments must be present in the intestine. When they become so deficient that their lack is recognized *in vitro* it may also be recognized by the grave and characteristic disturbances of digestion. Duodenal tubes and buckets I regard as ingenious toys which as yet have not justified their existence from the standpoint of practical results. No one could be more willing to welcome this assistance in diagnosis and indicating treatment than I, but at present their chief function appears to be the production of income and the delay of surgery.

To recapitulate briefly: Chronic pancreatitis may be suspected of having complicated gall-stone disease when the symptoms point to severe recurrent disease of the choledochus with marked emaciation and disturbance of the carbohydrate metabolism or evidence of insufficient action of the pancreatic ferments on the food in the intestine.

This liability of the pancreas to involvement by gall-stone disease is a strong argument for early operation in biliary infections or cholelithiasis.

The treatment of chronic pancreatitis itself is closely bound up with the surgery of the bile passages. In the surgical treatment of chronic pancreatitis Mayo Robson occupies the same position as Fitz does to the development of our knowledge of the disease. He was the pioneer in showing that free drainage of the biliary tract, and, through this outlet, drainage also of the pancreatic ducts would in many instances enable the pancreas to cast off the infection and resume its normal function. This is, in a nutshell, the principle of the treatment and, though it may seem roundabout, its efficacy has now been demonstrated too often to admit of a question. The easiest and most advantageous method of providing drainage is by a cholecystostomy. If for any reason this is impracticable, drainage of the common duct should be done. At times when the closure of the common duct is complete and likely to be lasting a cholecystenterostomy may be best, but as a general rule external drainage permits subsidence of the swelling of the pancreas and a reestablishment of the functions of the ducts. Drainage should be maintained for three or more weeks at least. It is difficult to keep the fistula from closing too soon, and in cases of marked pancreatic disease it is best to make a cholecystduodenostomy. Just how long such an opening will remain patulous is a question, for I have reoperated on patients on whom this operation had been performed and found the opening closed. It should not be forgotten also that cholecystduodenostomy is an operation of greater magnitude and slightly higher mortality than simple cholecystostomy.

Pancreatitis was formerly regarded as a most dangerous complication of cholelithiasis from the operative standpoint. This doubtless was due to the fact that only the most extreme cases were recognized. In the present series I lost only one patient. The argument for operation is all the stronger if pancreatitis is present, as the danger of chronic invalidism or death is even more pressing.

In spite of optimistic reports and some results of my own which seemed astonishing, I am not inclined to give too rosy a prognosis as to complete recovery in cases in which long-continued disease has caused marked sclerosis of the pancreas.

The best cure for pancreatitis is prevention, which means earlier intervention in calculous and non-calculous disease of the bile-passages.

1634 Walnut Street.

TRAUMATIC TETANUS

RECOVERY FOLLOWING THE ADMINISTRATION OF TETANUS ANTITOXIN

EDWARD N. LIELL, M.D.

JACKSONVILLE, FLA.

The following history evidences the successful use of tetanus antitoxin despite decided symptoms of lockjaw being manifested for three days antedating its use. Fifty-five thousand units of antitoxin were given in all.

History.—Jesse C., aged 10, was admitted to the isolation ward at St. Luke's Hospital, Jan. 5, 1909. He gave the usual history of traumatism, having been injured twelve days previously by the reckless use of a toy pistol, a portion of the wad and blank cartridge lacerating the middle finger of the right hand. On the ninth day following the injury, symptoms of rigidity of the muscles of the lower jaw developed, with slight convulsive seizures; subsequently, the muscles of the neck, chest and back became implicated. On the day of admission, at 2:30 p. m., he had a decided convulsion, which was repeated an hour later. At this time, the wound, of a charred character and but partly healed, was thoroughly excised and a bichlorid dressing applied.

Treatment and Course of Case.—At 4:30 p. m., I injected 5,000 units of antitoxin serum in the muscles over the right shoulder-blade; an enema of normal salt solution was also given.

January 6, 11 a. m., 5,000 units were again injected. Repeated convulsions lasting from a few seconds to two minutes occurred through the night; the patient slept at intervals only; though nourishment was refused, he took water frequently through a tube. At noon, he had a convulsion lasting a full minute. At 4:30 p. m., I injected 3,000 units; 1 pint enema of salt solution was also given.

January 7, 11 a. m., the patient slept at intervals through the night; muscles were contracted but not as rigid as the previous night. He had four convulsions within the past twelve hours; 3,000 units were again injected at this time. Five p. m.; the patient has had light convulsions almost every half-hour since noon; 3,000 units antitoxin were again injected.

January 8, 11 a. m., numerous convulsive seizures occurred during the night, varying in intensity from a few seconds to two minutes; the patient was very restless; refused both nourishment and medication, the latter being chloral and sodium bromid 10 grains each dose; he took water, however. I again injected 3,000 units of antitoxin. Seven p. m.; the patient had several convulsions since noon, one lasting eight minutes though not formidable in character; 3,000 units antitoxin were injected at this time.

January 9, noon, the patient had several severe convulsions through the night; he was very restless, the nurse being obliged to give morphin ⅙ grain hypodermically, as well as 20 grains chloral, per rectum, to control restlessness; 3,000 units antitoxin was injected. Seven p. m.; the patient had frequent light convulsions through the day. For the first time since the onset of convulsions, the muscles of the jaw and neck relaxed somewhat, so that the teeth could be separated 1 inch; 3,000 units were again injected.

January 10, 11 a. m., the patient had through the night eleven seizures, several of which were severe; however, he slept peacefully nearly an hour at one time; 3,000 units were again injected. Eight p. m.; there were several paroxysms during the day, though lighter in character; 3,000 units were injected.

January 11, 10 a. m., patient turned himself in bed, sleeping comfortably on the left side for three hours, with jaws relaxed, without any convulsive seizures during that period of time; he also flexed his limbs voluntarily; however, with this favorable turn in view, I injected 3,000 units. Eleven p. m.; several slight seizures occurred during the afternoon, followed by two severe convulsions about 10 p. m.

January 12, 11 a. m., the patient had seven light seizures through the night, but awoke feeling better; nevertheless I injected 3,000 units. Seven p. m.; paroxysms have been few and light through the day; the patient slept at intervals; 3,000 units were again injected.

January 13, 11 a. m., the patient slept better than usual through the night; turned over himself in bed this morning, asking for nourishment; only 1,500 units were injected this time. Eight p. m.; paroxysms have been light and far apart; the muscles of the jaw and other muscles are more relaxed; 1,500 units were injected.

January 14, 11 a. m., the patient had three severe convulsions through the night, though otherwise he slept well; 1,500 units were again injected. Eight p. m.; the patient had a comparatively quiet day, so no injection was given at this time.

January 15, 11 a. m., only two light seizures occurred during the night; the muscles were much more relaxed; the patient is less sensitve to touch and noise; 1,500 units were injected at this time. Eight p. m.; paroxysms have been few and superficial through the day. Twenty grains chloral were ordered to be given in place of the antitoxin injection.

January 16, the patient had a good night; occasional muscular contractions only occurred during the night; chloral was repeated for the night.

January 17, no paroxysms occurred during either night or day. The patient sat up in bed half an hour. Chloral was stopped.

January 18, the patient s ept well all night. He is now sitting up in bed; feeling very hungry, but somewhat annoyed by itching of the skin over the seat of the various injections.

From this time on the patient improved rapidly, having no further muscular contractions or paroxysms. The temperature ranges were from 99 to 101, the latter being on January 9, the seventh day of the convulsions and the sixteenth day following the time of injury. The pulse-rate varied from 84 to 122, the latter being on the 10th; while the respiration varied from 20 to 46. the latter being on the 9th, the date of highest temperature. The patient was discharged from the hospital, well, January 24.

In the statistics at my command referring to traumatic tetanus, the result of Fourth-of-July wounds, out of 350 collected reports of cases, but seven patients are positively known to have recovered. This gives a mortality of 98 per cent. Of these seven cases in which recovery was reported, in five prophylactic treatment had been resorted to before the toxin of tetanus had time to permeate the nervous system. In the other two cases, satisfactory results were attained despite decided symptoms of lockjaw manifesting themselves.

I am well aware of the general teaching advocated through the various state boards of health bulletins that, when tetanus has once developed, antitoxin is practically useless. Yet here is another instance in which recovery followed its administration, the intramuscular method being used because of its simplicity, 55,000 units being administered in all, the first injection being given three days after symptoms of lockjaw had manifested themselves.

140 West Monroe Street.

INFLUENZAL MENINGITIS AND ITS SERUM TREATMENT *

SIMON FLEXNER, M.D.

NEW YORK

That influenzal cerebrospinal meningitis is by no means a rare affection is being shown by the increasing number of reports of its occurrence. Within a few months, in the United States alone, reports dealing with the subject have been published by Wollstein, Dunn, and Davis. Moreover, the disease is highly fatal. All but six of the fifty-eight cases thus far reported in which the influenza bacillus has been detected in the cerebrospinal fluid, have terminated fatally.

Influenzal meningitis is more frequent among infants and children than among adults. It sometimes follows on undoubted influenza bacillus infections of the respiratory tract, and sometimes develops independently of obvious disease of that tract. Since the influenza bacillus is often present in the secretions of the respiratory mucous membrane in children, suffering from a variety of diseases, during the wide prevalence of influenza, it is probable that the infection of the meninges is always secondary to the respiratory infection. Moreover, all or nearly all cases of influenzal meningitis are examples of bacteriemia, since the bacilli have frequently been cultivated in large numbers from the blood during life or at autopsy.

The fact of the frequency and severity of influenzal meningitis was impressed on us at the Rockefeller Institute, where, for a period of several years, large numbers of specimens of cerebrospinal fluid have been examined bacteriologically in connection with the studies being conducted there on the serum therapy of epidemic meningitis. All the cases diagnosed by us as influenzal meningitis terminated fatally.

We undertook, therefore, the experimental investigation of this highly fatal disease. Dr. Wollstein was able to show, first, that the injection of virulent cultures of *Bacillus influenzæ* into the subdural space of several species of monkeys by lumbar puncture would set up a severe and usually fatal form of acute cerebrospinal meningitis that reproduced the clinical and pathologic effects observed in the spontaneous disease occurring in human beings. The effects of the inoculations begin to be apparent about five hours after the injection, and death may result as early as thirty-six hours after the inoculation, or it may be delayed for three or four days. The microorganisms multiply actively and pus cells are quickly poured into the membranes, but few or none of the bacilli are taken up by the cells. In human cases some of the bacilli are found inside cells, but the greater part also remain free in the fluid. From the subdural space the bacilli pass freely into the blood-stream and sometimes secondary localizations take place in the lungs and pleuræ, where inflammations are produced.

The experimental production of an influenzal meningitis was regarded merely as preliminary to the attempt to influence the course of the infection by means of the local application of a therapeutic agent. An efficient one for the experimental infection has been found in an immune serum prepared in the goat by the long continued, repeated injection of virulent cultures of *Bacillus influenzæ*. Dr. Wollstein is reporting in detail on this phase of the subject in a forthcoming number of the *Journal of Experimental Medicine*.

It has been found possible to rescue monkeys regularly from the fatal effects of the subdural inoculation of cultures of the influenza bacillus through daily injection, by means of lumbar puncture, of the immune serum for three or four days. Serum injections produce an arrest of the multiplication of the bacilli and bring about a free phagocytosis, with which is connected the cessation of the emigration of leukocytes and a consequent clearing of the cerebrospinal fluid. The fluid, at first turbid or purulent, tends to return to clear in three or four days, while cultures which are at first abundant become negative in that period or a little later. The bacteriemia is also brought under control and the secondary localization of the bacilli in the organs prevented. Recovery is, therefore, complete.

In view of the severe conditions surrounding influenzal meningitis in human beings, it would seem desirable to apply the serum to the treatment of the spontaneous disease. If this should be done, then every effort should be directed to the making of the bacteriologic diagnosis at the earliest possible moment, and the employment of a serum that has been prepared with virulent influenza bacilli and that shows a high degree of opsonic value. The manner in which the serum should be employed in human beings is indicated by the manner in which the serum for epidemic meningitis has come to be applied successfully. The testing of the anti-influenzal serum will be confined, for the present, to a few places in which its effects can be carefully observed and controlled before it is offered for more general use.

Sixty-Sixth Street and Avenue A.

* From the Laboratories of the Rockefeller Institute for Medical Research.

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THE ETHER RAUSCH

A SAFE AND CERTAIN METHOD OF PRODUCING BRIEF GENERAL COMPLETE ANESTHESIA WITH ETHER

WILLIAM T. COUGHLIN, M.D.
Assistant Professor of Surgery, St. Louis University
ST. LOUIS

I know of no perfectly satisfactory anesthetic; and that surgeons in general are not quite satisfied with our means of making surgery painless is shown by the many anesthetics, both local and general, with their various methods of administration. Each method and every anesthetic has its enthusiastic advocates, but I suppose that all agree with me when I say that an ideal anesthetic has yet to come into common use.

When in general practice I often felt the need of a safe method for producing brief general complete anesthesia for certain minor surgical operations. I shall, therefore, give, for the benefit of the general practitioner, a simple description of the technic of administration of, and my experience with, the ether *Rausch*. It may be that the method here described and advocated is one already used in certain clinics in our country, but I have talked with many, from all or nearly all of our principal cities, and I have met only one—Dr. Kelly of Cleveland—who had seen it used in the United States. Dr. Kelly informed me that the method had been in use in this country twenty-five years ago. Why has it fallen into disuse?

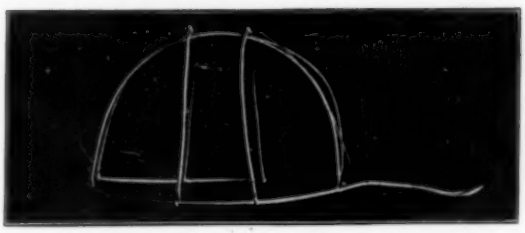

Fig. 1.—Wire frame of mask large enough to fit the face.

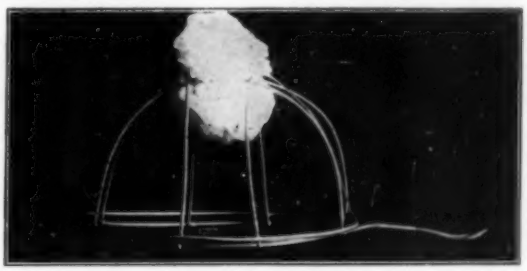

Fig. 2.—The same, with pad of gauze in position.

It is true that in some text-books on surgery attention is briefly called to the fact that a stage of primary anesthesia occurs early during the administration of chloroform and ether. Da Costa says (quoting Packard) that such is the case but that the primary anesthesia so induced lasts only half a minute. The anesthesia induced by the ether *Rausch* is profound, general and complete and it lasts at least three minutes and usually more than five. There is no nausea, vomiting or other unpleasant effect. As the patient begins to recover the mask may be reapplied and the anesthesia renewed, although this is rarely necessary.

Being in Dresden, I visited the clinic of Lindner one morning, and the subject of anesthetics came under discussion. I was an enthusiast for local and regional anesthesia, for I had watched with great interest the methods of Professor Reclus in Paris. I never saw anyone who knew so much about anesthesia in general and local anesthesia in particular as Professor Reclus.

I was asked by Professor Lindner whether I had ever used the *Aether Rausch*. I confessed that I had never even heard of it. He asked the assistant if there happened to be a case that morning on which it might be used and the latter replied that there was a large cervical abscess. Lindner therefore proceeded to illustrate his method—a method which he had then used, he believed, more than 5,000 times. The patient was placed on the table as for an ordinary anesthetic. All instruments, drains and dressings, etc., likely to be used were ready and close at hand. All those present were requested to be silent. The anesthetist took the mask—a large wire affair, such a one as that shown in the illustrations—and showed it to the patient, told the latter what was to be done, and admonished him to have no anxiety or alarm, explaining that the only unpleasant feature was the smell of the ether. The patient was asked to raise his arm and to keep it raised as long as he could. Meanwhile the pad at the bottom of the mask was saturated with ether, the mask was placed in position and the patient was told to breathe deeply. At about the twelfth inhalation, the arm wavered and began to fall; the mask was removed and at once the operation was begun and quickly finished. In a very short space of time three drains had been inserted and fixed in position. I was spell-bound. The mask had been removed at the first incision and the patient, though somewhat cyanosed, remained quiet. The cyanosis speedily disappeared; the patient opened his eyes, looked foolish, laughed, and asked where he was. Twenty minutes or so afterward we saw him as we passed through the ward; he was eating his dinner and seemed none the worse for his operation. He assured me that he had felt no pain whatever.

The method of Lindner is that until recently used by me at the Washington University Hospital and now used by me at the College Clinic, St. Louis University Medical School.

Every surgeon engaged in clinical or consultant practice sees almost daily cases in which the timely and thorough performance of some minor surgical operation would in all probability have effected a speedy cure. He sees many in which attempt at operation has been made, but without the success which the patient and perhaps the doctor expected.

I believe that in nearly all these cases the physician first in attendance knows what he wants to do. He realizes, for example, that a free early incision with efficient drainage is urgently indicated in a palmar phlegmon, but he does not like to subject his patient to the risk of a general anesthetic or one which necessitates the expense of an assistant, and his patient is not willing to have any extra expense. He uses a local anesthetic, perhaps novocain, cocain or ethyl chlorid. Now you who have used these know that when tissues are acutely inflamed one is likely to cause a good deal of pain when applying the local anesthetic; and, furthermore, after having applied the local anesthetic one is usually far from having secured a complete anesthesia. The surgeon uses a local anesthetic and inflicts pain

when operating. The patient struggles or cries or orders him to desist. At any rate, the surgeon ceases before the operation is as well done as he could wish—before it is properly done. The case drags on with him. The process is perhaps repeated several times. The patient at last seeks relief elsewhere and the reputation of the first in attendance suffers in consequence.

It is in these cases that I advocate the use of the ether *Rausch*. I have used it now in more than two hundred cases, in the clinic, in the office and in the home. I have used it in cases in which I have had plenty of assistants and also in a few cases in which I have had to act both as anesthetist and as operator. I have never failed to secure complete anesthesia, except in cases in which the patient refused to proceed beyond the first two or three inhalations.

The *Rausch* may be given in a variety of ways; no special appliance is necessary. The principle to remember is this: that the ether is to be administered with very little air; the air must be excluded as much as possible. I have used it in the home by means of a couple of wet towels rolled in the form of a hollow cylinder or cone with an ether-saturated towel or cotton-wool over the upper end. Often I have used an ordinary derby hat. This is made to fit the patient's face closely by means of wet towels placed around the edge,

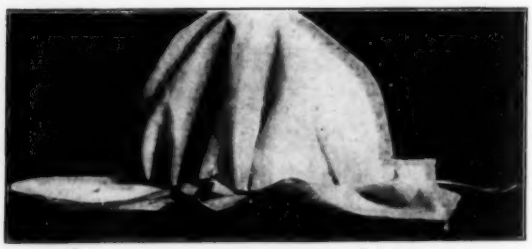

Fig. 3.—The same, now covered with oiled silk.

and wet towels are placed around the sides and over a portion of the top; the wet towels exclude the air better.

I have tried the ordinary open mask in many cases. My objection to it is that I have never found it satisfactory. That it takes more time may seem a trifling objection; but the patient often becomes much frightened and refuses to proceed. The parents or relatives fear that the patient is to be completely anesthetized and become alarmed. The patient often becomes sick at his stomach, something I have never seen happen either during or after the *Rausch*. Furthermore, with the open mask it is difficult to tell just when primary anesthesia has been induced because the arm sign fails, the arm falling through fatigue.

I have been using the *Rausch* now for over two years; I have used it more than two hundred times. I recommend its use in all minor surgical operations which can be better done if the patient feels no pain. I have used it in opening abscesses, setting fractures, reducing dislocations, removing ingrown toe-nails, etc., etc.

I would not use it in the presence of chronic bronchitis, emphysema, marked arteriosclerosis or generally in disease of the pulmonary or cardiovascular system. Nor would I use it in any case in which the operation required more than five minutes' time to perform, or in those in which general relaxation is necessary. Neither would I use it in those pale, flabby children in whom one fears to encounter the "status lymphaticus."

Metropolitan Building.

A NEW SPLINT FOR TRACTION AND COUNTER-TRACTION IN FRACTURES OF THE HUMERUS *

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Traction and counter-traction in the treatment of the femur as devised by Buck fifty years ago was so simple, effective and satisfactory, that no substantial improvement thereon has been made, or is needed.

Traction and counter-traction in the treatment of fractures of the humerus, while not so universally necessary, is often desirable, and sometimes essential. Its need is expressed by Scudder, Eisendrath, and other American writers, without offering practical means for meeting it. Bardenheuer, of Cologne, has exploited and developed the application of traction and counter-traction to every part of the body, giving most elaborate details for its execution. His apparatus for the arm, however, is very complicated and unwieldy. Modifications of it have been offered by various German surgeons, the most ingenious and available being that of Hoffmann, who adapts the Mitteldorpf triangle into a rhom-

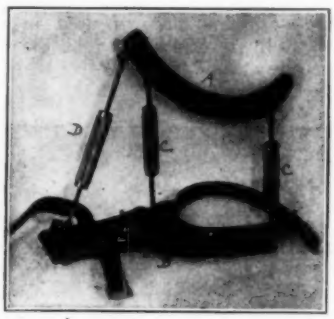


Fig. 1.—Traction splint for humerus. *A*, axillary crutch; *B*, forearm board; *C*, parallel rods through which traction is secured; *D*, guy-rod for maintaining forearm at right angle.

bus. The only ingenious and practical device I have seen described in this country, is by Osgood and Penhallow.[1]

They submit a tin gutter-splint, moulded to fit the arm, forearm and thorax. It would seem to be ideal, except for not permitting of elevation, graded traction, or reversal for the opposite arm.

The distinctive features of the device which I submit are an axillary crutch, *A*, for counter-traction, and a forearm board, *B*, for traction; the two being forced apart by parallel rods, *C*, extended by turnbuckles; the forearm being held meanwhile in right-angled flexion by a guy-rod, *D*, reaching to the axilla. After applying, the traction is employed and can be carried to any necessary extent. Under this powerful traction, there is opportunity for adjustment and manipulation of the fragments, and *x*-ray examination. There is ample space for coaptation splints, for applying pressure by compresses at required points, and for frequent dressings of blisters or wounds. After full reduction and adjustment, the extreme tension can be somewhat relaxed, if the fracture is not spiral or oblique. In ordinary cases the appliance should be held to the body by a swathe; but in cases in

* Read at the semi-annual meeting of the New Haven County Medical Society, April 27, 1911.

1. THE JOURNAL A. M. A., July 31, 1909, p. 375.

which it is necessary to maintain elevation and abduction of the humerus, the entire apparatus can easily be held up in the air, by a rod passing from the elbow to a belt at the waist; though a shoulder-girdle would be required to keep the axillary crutch from slipping down.

By unscrewing one turnbuckle, *D*, the whole affair turns inside out, and when the turnbuckle is replaced, we have a complete apparatus for the opposite side.

The size of the crutch is such as to minimize axillary pressure. Pressure on the radial surface of the forearm must be guarded against by thorough padding, which can be supplemented by a pneumatic pessary. Traction is exerted only by the two posterior turnbuckles—the front one being used simply to maintain right-angled flexion of the elbow.

This device may bear very slight resemblance to the one which will finally be generally adopted by the profession, but I hope it may be a link in the chain of evolution which is destined eventually to make traction and counter-traction of the humerus as efficient, positive and available, as it now is in the thigh.

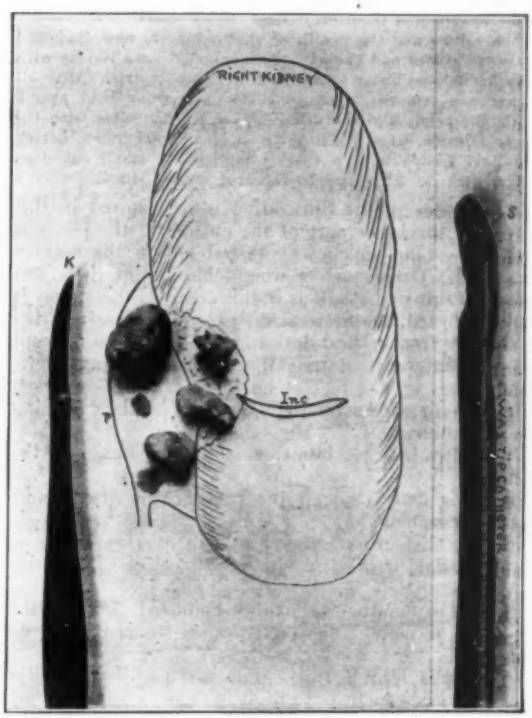
Fig. 2.—Traction splint applied to humerus.

A NEW AND SIMPLE METHOD OF REMOVING A RENAL CALCULUS

HOWARD A. KELLY, M.D.
BALTIMORE

In dealing with renal calculi in instances in which the previous examination has shown that the kidney is good enough to be saved, we need to have a variety of methods at our disposal in order to treat all patients satisfactorily and successfully. No one method will do, but we must vary our procedure according as the kidney is fixed or movable and according as we have a solitary stone to deal with, free in the pelvis of the kidney, or as the stone is branched and projects into the calices. Again, if the patient is very stout, and we have a long twelfth rib, we may be compelled to modify our technic.

A nephrolithotomy carefully done is a very safe procedure; if it is clumsily done, it may easily cost the life of the patient. On account of the risks from hemorrhage, there is a strong tendency to turn to pyelotomy, a good, neat operation when the stone is in the pelvis and the kidney is movable enough to be drawn well up into the wound, and when there is not too much surrounding inflammation. If we follow up the avascular zone on the posterior surface of the kidney near its lower pole, then we can make a pyelonephrotomy with advantage in the removal of larger stones, especially those fastened in the lower calices (Albarran-Broedel).



The right kidney is shown in outline with its pelvis to the left containing the stones, of which there are five. The little mass below the ureteral orifice is the calculous debris. The wax-tipped catheter is shown on the right, and *S* points to the scratch-marks by means of which the diagnosis of stone was made. This is from an untouched photographic enlargement (about three times). The blunt knife, *K*, is shown on the left, reduced to about three-fifths of its actual size. With this the incision (Inc.) was made in the dorsum of the kidney inclining to the left side, opening the pelvis. Through the blunt opening made in this way into the kidney, distended with a solution of silver nitrate, the stones were grasped and extracted and the upper urinary tract thoroughly washed out.

I have devised and used at intervals a transrenal plan of nephrolithotomy which, except in the simplest cases, with an easy exposure, is, I think, quicker and safer and better than pyelotomy or any other transrenal operation, and I am now inclined to accord to it a wide field of utility. It is as follows:

TECHNIC

A renal catheter 1.75 mm. in diameter, large enough to obturate the ureteral orifice and prevent a reflux of fluid into the bladder, is inserted through an open-air cystoscope and introduced well up to the kidney just before giving the anesthesia.

The patient is then put to sleep, preferably with gas, semiprone, on an Edebohls cushion. An incision is made in the

loin and the superior lumbar triangle is pulled open and the kidney exposed and freed on all sides from its fatty capsule.

The stone is then felt and the kidney gently loosened as far as possible on all sides and brought towards the wound. Then an assistant forces fluid (1/1,200 silver nitrate) into the renal pelvis, until it puffs out tense. As a rule, with a careful preliminary study, the exact capacity of the renal pelvis is already known. Then when the pelvis and kidney are swollen up tense the surgeon first incises the capsule and then plunges a blunt-pointed and blunt-edged knife (see illustration) through the cortex on the posterior surface, easily entering the renal pelvis at once and enlarging the incision, in a transverse direction if the stones are small. There is a gush of fluid which stops as he introduces his finger and feels for and finds the stone, which he at once grasps with a small stone forceps and removes.

The calices and the mouth of the ureter are now examined for more stones and the kidney is palpated on all sides with both hands, one finger being inside the renal pelvis. After all stones are removed, the wound is plugged or held closed, while the pelvis and the calices are again distended with the silver solution, when the finger is suddenly withdrawn, letting the fluid escape with a rush, bringing any small calculous *débris* with it. This may be repeated several times.

The stones in the illustration were removed in this way. In the lower part of the outline of the pelvis is seen some sand which was washed out in the manner described. Often such a wound bleeds but little and needs no suturing at all, as in this case. If the kidney is badly infected, the ureteral catheter may be left in the ureter for from several days to a week or more for constant or intermittent irrigation with a mild antiseptic fluid.

I wish to emphasize the following points regarding the operation:

1. It involves a minimal amount of damage to the kidney.

2. It is done through the part of the organ most easily accessible.

3. The distention is invaluable in offering a bag of fluid, overlaid with a zone of soft tissue, which is easily punctured.

4. An exploration is easily conducted through the opening, revealing the presence or absence of other calculi.

5. If it is desirable to keep it open a while for drainage the transverse incision is a good one for this purpose, as it can be left open and will close rapidly when the irrigations are omitted.

6. In the last case in which operation was done, no sutures were put into the kidney, and yet there was no escape of urine after twenty-four hours and practically no bleeding through the incision.

1418 Eutaw Place.

The Origin of New Cults.—Most men are subject to irregularities in their supply of energy. Sickness, disaster, bad food, and many other conditions produce this result. In consequence, most men at intervals pass from one extreme to the other. Downward curves bring doubt, fear and depression; upward curves create men anew and give the higher powers an unwonted supply of energy. It is during the dominance of the upward movement that suggestion is potent and new beliefs are readily formed. The many plans of recent origin for the suppression of pain and the inculcation of invigorating beliefs have their bases in this thought, even if the mode of expressing it is so immaterial that the physical background of the mind is ignored. To keep the thought of pain out of the mind when depression tends to make it vivid, and to utilize the early epochs of recovery for presenting suggestive ideas, are two rules that work wonders in rebuilding the higher life among those temporarily depressed. (From Patten's "The Social Basis of Religion," New York, 1911.)

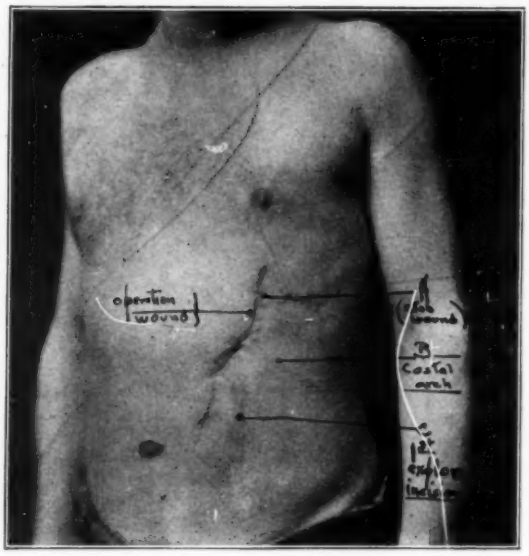
A CASE OF INCARCERATED AND OBSTRUCTED DIAPHRAGMATIC HERNIA WITH OPERATION AND RECOVERY

BENNETT V. CAFFEE, M.D.
TERRE HAUTE, IND.

While the literature on diaphragmatic hernia is fairly voluminous, there *seem* to be very few reported cases of operation with recovery; many of the cases were discovered post mortem; in others the patients died following operation. A synopsis follows of those discovered after a fairly extensive search.

CASE 1.—A patient[1] of 23; diagnosis, obstruction of bowels. Operation through median incision above navel; colon found passing through rent in diaphragm; second incision along border of costal arch; colon being firmly attached, hernia could not be reduced; artificial anus made (colostomy). Recovery with subsequent closure of colostomy opening.

CASE 2.—Male,[2] aged 18; signs of obstruction after violent exercise. Incision through rectus in upper abdomen; transverse colon, omentum and greater part of stomach protrude through rent in the diaphragm 3½ inches long; omentum adherent to pleura; thorax then opened by rib resection; hernia reduced; patient's condition too low to permit suturing of diaphragm; abdominal wound closed; rent in diaphragm held together by gauze packing through thoracic opening. Recovery complicated by empyema; no return of hernia apparent.



Location of the abdominal and thoracic operation wounds in the case of diaphragmatic hernia reported.

CASE 3.—A boy,[3] aged 11, had been injured in the eleventh intercostal space, resulting in a hernia; two ribs were "osteotomized, not resected." The hernia was reduced and the rent repaired without opening the abdominal cavity. Recovery.

CASE 4.—A man,[4] aged 23, stabbed in the left seventh intercostal space seven years before; taken with mild symptoms of intestinal obstruction, tenderness and rigidity over abdomen, especially over appendix. Operation six days after first symptoms; median incision; a knuckle of colon protruded through very small rent in diaphragm at site of old scar; too firmly adherent to detach; lateral anastomosis. Recovery.

1. Leuw, C.: Cor.-Bl. f. Schweiz. Aertze, 100, xxxi, p. 231.
2. Dannis, W. A.: St. Paul Med. Jour., 1905, vii, 736.
3. Postempski, P.: Bull. d. r. Accad. med. di Roma, 1888-9, xv, 191.
4. Bamberger, A.: THE JOURNAL A. M. A., Dec. 31, 1910, p. 2296.

CASE 5.—The case which I report was in a glass blower, aged 25. He had received a stab in the left mammary line, cutting through the costal cartilages of the seventh and eighth ribs. The omentum protruded between the cut ends, plugging the opening. The abdominal cavity was opened and the contents examined, but no perforation was found. The omentum was resected and returned through the stab-wound; the opening in the diaphragm could not be closed.

Healing was by primary intention. Four months later, after the patient had been blowing glass one month, he stepped off from a porch; he felt a sudden pain in the region of the stab-wound. Symptoms of intestinal obstruction immediately ensued—severe pain, vomiting, etc. He was taken to the Union Hospital twelve hours after onset of symptoms and an incision made below the left costal arch. The splenic flexure of the colon was found closely adherent to the diaphragm, in which a very small opening sufficient to admit the index-finger could be felt; the costal arch was then cut through almost to the site of the old stab wound. After retracting the ribs the colon was released, only a knuckle of it having passed through. The opening in the diaphragm was then securely sutured by two chromic sutures passed through the sixth intercostal space on the index-finger as a guide. The wound was closed and healed promptly. The photograph from which the accompanying illustration was made was taken six weeks after the operation. The patient has been working since, though not at his trade, with no return of his symptoms.

An interesting feature is that the patient correctly diagnosed the hernia before I was called, as he had been warned of the danger of it.

A PLATE-CHANGING DEVICE FOR STEREOSCOPIC RADIOGRAPHS OF THE CHEST

SIDNEY LANGE, M.D.
CINCINNATI

Stereoscopic *x*-ray work demands the taking of two radiographs from different angles and the subsequent superimposing of the plates by viewing them through prisms or in a Wheatstone stereoscope. After exposure the first plate must be removed and a second one must be substituted.

With the improvement of *x*-ray apparatus it has become possible to make two radiographs of the chest in the space of a few seconds; that is, while the patient suspends respiration, and thus to obtain true stereoscopic pictures of the chest. But the problem of quickly removing one photographic plate and substituting a second has been a serious hindrance in this work.

The following simple method has been devised to change the plates: A sheet of lead, 1/8 inch thick, is provided on both sides with small clamps sufficient to hold a photographic plate against each aspect. This sheet of lead is then suspended at two points in a metal frame so that it can revolve around a horizontal axis (Fig. 1). A spiral spring (shown faintly in Fig. 1) made of stiff wire is attached to one end of this axis and when wound, by revolving the lead sheet, tends to unwind and revolve the lead in the opposite direction. The frame is hinged to some sort of chair or other upright support in which the patient sits or stands (Fig. 2). A thin sheet of aluminum is placed between the plate-changing device and the patient's chest, against which the patient leans.

The apparatus is operated as follows: Two photographic plates in their light-proof envelopes are inserted one on each side of the sheet of lead. The spring is wound by revolving the lead sheet one-half revolution. The patient is instructed to take a deep breath and hold it and the first exposure is made on one plate, the second plate on the opposite side being protected from the *x*-ray by the intervening sheet of lead.

By means of a string attached to the lower margin of the frame, the operator (in his protected booth) pulls the frame outward and thus allows the spring to revolve

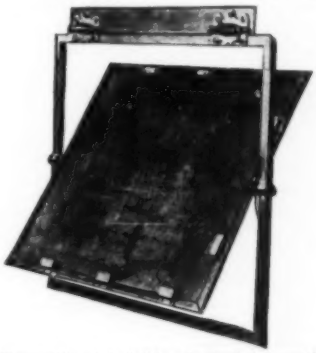


Fig. 1.—Radiographic plate-holder devised for rapid changing of plates.

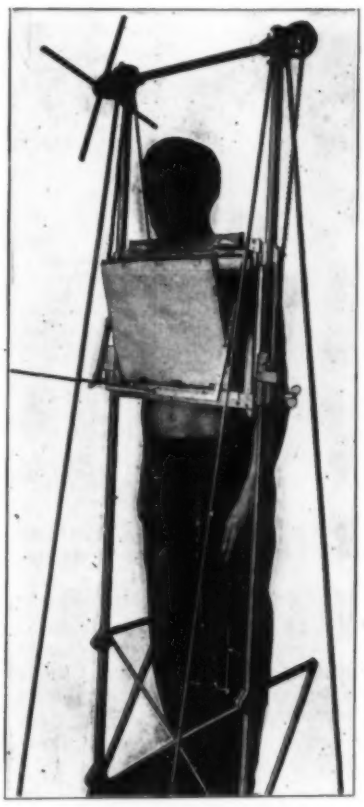


Fig. 2.—Plate-changing device in position for use.

the sheet of lead, and with it the photographic plates, one-half of a revolution. On dropping the frame back into position the second plate will have exchanged places with the first and the second exposure is made. Of course provision must be made for shifting the *x*-ray tube at the same time.

In order to limit the vibration of the sheet of lead after the change is made and to cause it to come to rest quickly, a small spring snap has been placed on the lower margin of the frame, but is not shown on the accompanying illustrations. This is very important, otherwise several seconds may be lost while waiting for the apparatus to settle down before making the second exposure.

The apparatus as here shown can be used only in the upright position.

22 West Seventh Street.

A VEST-POCKET CASE FOR CARRYING EVERYTHING NECESSARY FOR MAKING A BLOOD-COUNT

M. BOYD KATZENSTEIN, B.Sc., M.D., M.Sc.
PITTSBURG

When making routine blood examination on patients, it is necessary to have blood pipettes at hand at all times. On account of the inconvenience of carrying them, solutions and pipettes are usually not at hand when wanted.

Fig 1.—The pocket blood-counting case complete.

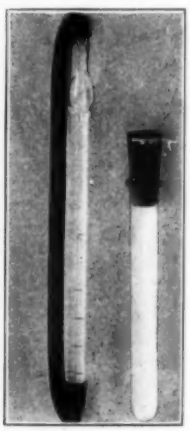


Fig. 2.—Sealed pipette and small test-tube for solution.

I have devised a little case, which can be slipped into the vest pocket and be ready at any time to make a blood-count.

It is a small leather pencil-holder and contains white and red blood pipettes; a small trocar, such as is found in a surgical pocket set, to be used for pricking the finger; two small rubber tubes, without the bone mouthpiece and two very small test-tubes for the diluting fluids (Fig. 1). All these parts are very easily secured and assembled, at a very small expense, the only item of expense being the blood pipettes. The two small tubes, while in the case, are either empty or may be filled with solution. If empty the diluting fluids can easily be made at the bedside by putting two or three drops of vinegar in the little tube and filling it with water. This makes a satisfactory diluting fluid for leukocytes. Into the second tube should be put a very small pinch of salt and it should be filled with water. This makes a satisfactory solution for the red corpuscles. For hemoglobin the test color sheet and a few pieces of filter-paper may be torn out of the Tallquist book. This can easily be slipped into the little case.

For sealing the pipettes for transportation I have two methods. In one I use the tube by which the fluid is drawn into the pipettes; this tube is to have no bone mouthpiece and it will be found just as convenient without it. After the pipette is filled with solution and is thoroughly shaken, the tube is brought down and the free end passed over the pointed end of the pipette, as shown in Figure 2. One should always see that the pointed end of the pipette is dry before slipping on the little tube. The second method is as follows: For this two parts are necessary for a single tube, both easily attainable and made by the user. The first part is a simple small rubber stopper such as is used to seal the small vials that usually contain serums; these are just large enough to fit into and completely close the upper wide opening of the pipette. The second is a small rubber tube of small caliber, such as is used in drawing the blood and solution into the pipette. This piece of tubing should be 2 cm. long and have a caliber of 0.5 cm.; one end being plugged by the large end of the small rubber stopper, such as is mentioned above (Fig. 3).

In use, the blood pipette is filled in the usual manner, is well shaken to mix the solution and blood and a small rubber tube slipped over the pointed end of the pipette; this will force a small part of the fluid up into the upper expanded portion of the pipette (no fluid is lost); then the small stopper is inserted and the outfit is ready for transportation.

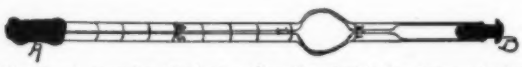


Fig. 3.—A second method of sealing the pipette for transportation.

When one is ready to make the count the tube is opened in just the opposite manner to closing. The little rubber stopper is first removed, then the closed rubber tube, and it will be found on removing the tubing that the fluid that was forced out of the bulbous portion of the pipette will be again drawn into it. The pipette is again well shaken and is then ready for a count to be made, the dilution remaining accurate.

The pipette can be carried in any position.

8110 Jenkens Arcade Building.

Treatment and Prevention of Measles.—In the treatment of both measles and scarlet fever, Robert Milne, M.D. (*Proc. Royal Soc. Med.*, April, 1911), claims to have carried out the following treatment with surprising results in the cure and in the prevention of the spread of these infections, even in institutions, without adopting methods of isolation or disinfection. He first used phenol in oil 1 to 10. For twenty-seven years, however, he claims to have used pure eucalyptus oil. During the first four days, commencing at the earliest possible moment, this oil is gently rubbed in, morning and evening, all over the body. The treatment is kept up until the tenth day of the disease. The tonsils and pharynx are swabbed with 1 to 10 phenol in oil every two hours for the first twenty-four hours, rarely longer. He claims for this treatment that when it is begun early, secondary infections never occur and complications are unknown. With the treatment carefully carried out, children may occupy the same room and even the same bed without risk of infection. No quarantine is necessary and other children in the family may be allowed to attend school. No after disinfection is necessary. Milne gives his experience in public institutions among large numbers of children in which this plan of treatment resulted successfully.

TREATMENT BY VACCINE THERAPY OF A CARBUNCLE IN A DIABETIC

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The brilliant results produced by the use of *Staphylococcus aureus* vaccine in the treatment of carbuncles is already too well known to require further discussion. The following case, however, I am sure, is of sufficient interest to warrant reporting:

History.—Mr. R., aged 48, had been suffering with diabetes for three years, during which time he had lost 30 pounds and on several occasions had suffered from numbers of furuncles. In January of last year a large carbuncle appeared on the back of his neck. It was well opened and packed, but continued to discharge profusely for six weeks, with little or no sign of healing. At this time he was referred to me for vaccine treatment. A culture was taken and the causative organism found to be *Staphylococcus aureus.*

Fig. 1.—Carbuncle in a diabetic, treated with staphylococcus vaccines. Picture taken before inoculations were begun.

Fig. 2.—Picture taken after three inoculations with staphylococcus vaccines; appearance twenty-three days after first inoculation.

Treatment.—An autogenous vaccine was prepared and the patient inoculated with 100,000,000 dead staphylococci. For two days following the inoculation the discharge was somewhat increased and the patient complained of slight soreness at the site of inoculation. By the end of the first week the discharge had decreased about 75 per cent.; the soreness and induration about the carbuncle had greatly diminished. At this time a second inoculation of 200,000,000 dead staphylococci was given, followed by almost complete arrest of the discharge, induration and pain. A third inoculation of 200,000,000 staphylococci was given on the fourteenth day, with continued improvement, and on the twenty-third day his neck was entirely healed, as shown in Figure 2. The patient was now advised to present himself for an inoculation once every six weeks, with the hope of preventing a recurrence of both the carbuncle and furuncles. He followed this plan very faithfully and up to the time of making this report has been entirely free from either condition, although his diabetes has been taking its usual course.

254 Lennox Building.

SODIUM CACODYLATE IN SYPHILIS

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I have been using sodium cacodylate in three cases of secondary and one case of tertiary syphilis. Each dose contained 3 grains of the drug. The cases are as follows:

CASE 1.—A. M., male, aged 31, married, had been under mercurials and tonics for eight months. The only lesions present were two small mucous patches on the side of the tongue. Mercury was discontinued. On April 26, April 30 and May 10 the patient received 3-grain doses of sodium cacodylate. May 12 the patient was attacked by very severe cephalalgia, requiring opiate by hypodermic method to relieve. Mercury by inunction soon controlled the trouble.

CASE 2.—Mrs. A., aged 28, had just recovered from secondary skin lesion under mercury. On April 26 and April 30 she received hypodermic injections, each containing 3 grains of the drug, into pectoral muscle. May 15 brown patches appeared on the arms and chest. Proto-iodid by mouth caused them to disappear in a week.

CASE 3.—F. A., male, aged 35, married, had secondary mucous patches on the lower lip, pharynx and tonsils. He received three injections, on April 26, April 30 and May 10. No effect on mucous patches, and skin lesions followed. Proto-iodid given by mouth, and solution of mercuric nitrate, applied to patches, made great improvement in a week.

CASE 4.—A. D., male, aged 33, unmarried, had tertiary syphilids on the face, neck and chest, which had nearly disappeared under potassium iodid. This was discontinued and sodium cacodylate used hypodermically at six-day intervals, for three doses. In four weeks skin lesions reappeared. Potassium iodid was resumed, and the lesions were gone in two weeks.

It is evident that sodium cacodylate was useless in my cases and even harmful, inasmuch as the patients all suffered relapses under its use.

COMPARATIVE RESULTS OF DRY AND WET TEST-MEALS *

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The results regarding the secretory function of the stomach obtained by the original Ewald-Boas test-breakfast are not so conclusive as it was originally assumed, mainly on account of the closely interrelated and overlapping effect of motility and secretion. The gastric contents obtained after an Ewald-Boas test-breakfast, are made up of ingested bread and water, mucus, saliva,

* Read before the American Gastro-Enterological Association, at its fourteenth annual meeting, held at Philadelphia, April 20, 1911.

and gastric juice. It has been impossible to determine the proportion of gastric juice in the stomach contents. Boas suggested that a dry test-breakfast, consisting of a roll without water, would be a more accurate index of gastric secretion. Such a test would also eliminate the error due to the possible stimulating effects of water. Dry test-meals, consisting of a roll, and wet test-meals, consisting of a roll and 400 c.c. of water were given to forty-seven patients on alternate mornings, for a series of days, with a view of comparing the quantity of gastric contents, the total acidity and the amount of free hydrochloric acid. In patients suspected of continuous gastric secretion or of retention, gastric lavage was done before and after the tests were given to determine that the stomach was empty.

4. In proportion of two to one, the acidities obtained after a dry test-meal are greater than those obtained after a wet test, the exact figures being as follows: In thirty-three cases the results after a dry test were greater than after a wet test, and in fourteen cases after a wet test-meal the results obtained were greater than those after a dry test.

5. In all cases of pyloric stenosis, the results obtained after a wet test-meal have been greater than those obtained after a dry test-breakfast.

6. In myasthenia gastrica in which there is delayed motility, the results regarding the acidity obtained after a dry test-meal have been usually greater than those obtained after a wet test-breakfast, because in the case of the wet test, water remains in the stomach to dilute the juice.

7. In cases of disordered motility, the dry test-meal is a more accurate index of the secretory function of the stomach than the wet.

TABLE SHOWING AVERAGE OF COMPARATIVE RESULTS OF DRY AND WET EWALD TEST-MEALS *

The following are cases in which the results from the dry test-meals were greater than those obtained from the wet test-meals:

Patient	Diagnosis	Volume		Free HCl		Total Acidity	
		Wet, c.c.	Dry, c.c.	Wet	Dry	Wet	Dry
9888	Hypersthenic gastritis	152^{3}	56^{2}	34^{3}	34^{2}	66^{3}	73^{2}
856	Hypersthenic gastritis	60^{1}	60^{1}	5^{1}	9^{0}	78^{1}	86^{1}
10801	Hypersthenic gastritis	49^{0}	60^{1}	29^{2}	28^{1}	57^{2}	76^{1}
9961	Hypersthenic gastritis	168^{5}	124^{7}	54^{3}	55^{3}	75^{3}	70^{7}
986	Hypersthenic gastritis	105^{1}	75^{1}	32^{2}	30^{1}	48^{1}	62^{1}
10800	Hypersthenic gastritis	112^{1}	67^{1}	28^{2}	32^{0}	60^{1}	70^{1}
10769	Asthenic gastritis	96^{1}	60^{2}	21^{2}	17^{2}	45^{3}	54^{6}
11048	Asthenic gastritis	66^{0}	77^{4}	0^{0}	0^{4}	22^{0}	27^{4}
15500	Asthenic gastritis	102^{7}	40^{4}	10^{7}	12^{4}	33^{7}	44^{4}
11011	Asthenic gastritis	77^{3}	87^{2}	0^{3}	0^{2}	21^{3}	22^{2}
457	Myasthenia gastrica	45^{3}	11^{3}	3^{3}	14^{3}	47^{3}	47^{3}
478	Myasthenia gastrica	90^{3}	67^{3}	6^{3}	28^{3}	38^{3}	73^{3}
15551	Myasthenia gastrica	142^{3}	112^{3}	33^{3}	62^{3}	68^{3}	111^{3}
978	Myasthenia gastrica	105^{1}	65^{1}	21^{1}	38^{1}	32^{1}	70^{1}
15505	Neuroses	540^{4}	52^{4}	22^{4}	28^{3}	52^{4}	63^{5}
15550	Neuroses	150^{1}	150^{1}	0^{1}	38^{1}	36^{1}	80^{1}
70	Neuroses	150^{2}	45^{1}	19^{2}	12^{1}	47^{2}	52^{1}
15498	Duodenal ulcer	172^{2}	90^{1}	93^{2}	92^{1}	115^{2}	124^{1}
658	Pyloric ulcer	160^{3}	360^{1}	39^{3}	56^{1}	64^{3}	94^{1}
15432	Lymphosarcoma	150^{1}	60^{1}	18^{1}	22^{1}	38^{1}	50^{1}
15530	Cirrhosis of liver	150^{1}	40^{1}	20^{1}	32^{1}	60^{1}	72^{1}
30	Adhesions pyloric	170^{1}	67^{1}	30^{1}	30^{1}	69^{1}	70^{1}
107	Carcinoma intest.	142^{2}	102^{2}	2^{2}	5^{2}	31^{2}	34^{2}
201	Cholecystitis	90^{2}	164^{4}	35^{2}	66^{2}	68^{2}	78^{4}
453	Cancer	60^{2}	60^{2}	5^{1}	9^{1}	30^{2}	44^{1}
741	Osteosarcoma	140^{2}	35^{1}	13^{2}	30^{1}	35^{2}	50^{1}
856	Gastrosuccorrhea	60^{1}	60^{1}	36^{1}	34^{1}	78^{1}	86^{1}
9962	Hyperchlorhydria	135^{3}	30^{1}	40^{2}	45^{0}	75^{2}	70^{2}
948	Hyperchlorhydria	115^{3}	20^{1}	41^{3}	30^{1}	53^{3}	68^{1}
1082	Hyperchlorhydria	20^{2}	155^{1}	46^{2}	42^{1}	34^{2}	76^{1}
1129	Hyperchlorhydria	105^{1}	105^{1}	44^{1}	14^{1}	78^{1}	48^{1}
981	Endocarditis	90^{2}	65^{1}	0^{2}	0^{1}	10^{2}	24^{1}
338	Pleurisy (dry)	180^{1}	60^{1}	12^{1}	14^{1}	46^{1}	60^{1}

CASES IN WHICH THE RESULTS FROM THE WET TEST-MEALS WERE GREATER THAN THOSE OBTAINED FROM THE DRY TEST-MEALS

Patient	Diagnosis	Volume		Free HCl		Total Acidity	
		Wet, c.c.	Dry, c.c.	Wet	Dry	Wet	Dry
10927	Stenosis of pylorus	423^{10}	307^{8}	67^{10}	55^{8}	88^{10}	87^{6}
1040	Stenosis of pylorus	200^{1}	90^{1}	34^{1}	32^{0}	60^{1}	58^{1}
160	Stenosis of pylorus	198^{3}	78^{4}	41^{3}	26^{4}	74^{3}	54^{4}
10788	Myasthenia gastrica	270^{2}	195^{1}	20^{2}	20^{1}	64^{2}	60^{1}
1068	Myasthenia gastrica	60^{1}	60^{1}	6^{0}	25^{1}	86^{1}	35^{1}
449	Myasthenia gastrica	52^{2}	32^{0}	36^{2}	26^{2}	78^{2}	56^{2}
11190	Asthenic gastritis	34^{1}	40^{2}	10^{1}	4^{2}	25^{4}	19^{2}
1	Neuroses	180^{3}	95^{1}	19^{3}	0^{1}	47^{3}	52^{1}
221	T. B. sinus, amyloid	160^{3}	45^{2}	6^{3}	2^{2}	42^{3}	32^{2}
58	Cancer stomach	225^{2}	15^{1}	0^{2}	0^{1}	25^{2}	18^{1}
802	Hyperchlorhydria	270^{1}	105^{2}	66^{1}	53^{2}	92^{1}	90^{2}
1042	Chronic appendicitis	60^{1}	15^{1}	42^{1}	34^{1}	72^{1}	54^{1}
1064	Gastroduodenitis	340^{1}	200^{1}	52^{1}	44^{1}	76^{1}	72^{1}
1066	Diabetes	135^{1}	20^{1}	36^{1}	16^{1}	78^{1}	48^{1}

* Cases from the medical department of Prof. Edward Quintard, New York Post-Graduate Hospital. The small figures above and to the right of the figures in columns indicate the number of tests with the given result in each test.

1. Comparatively slight differences in the volume expressed and in the acidities obtained were noted in the results between the dry and wet test-breakfasts, suggesting a correlation existing between motility and secretion—a tendency to automatic regulation of the gastric function. The variation between wet and dry tests is, however, greater than between wet and wet tests, and between dry and dry tests.

2. The dilution of the juice by water is greater than the stimulating effect of water on the peptic glands.

3. The volume obtained after a wet test-breakfast is practically always greater than after a dry test-breakfast. No definite relationship could be made out between the volume and the acidity.

8. In order further to assist in solving the relationship existing between motility and secretion, the fluoroscope in conjunction with bismuth will be of great assistance.

The part which fatigue plays in the rate with which the stomach empties itself has, with the assistance of the fluoroscope, already been taken up, but the material so far has not allowed of any conclusions. It is, however, a line of investigation which appears very promising, particularly in view of the new fundamental discoveries regarding tonicity presented by Dr. Cannon.[1]

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1. Proc. Am. Gastro-Enter. Assn., 1911.

INJURY TO THE CHEST PRODUCING SIGNS OF ABDOMINAL INJURY

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History.—Mr. F. A., aged 30, was shot from below, by a person standing on the sidewalk, the bullet going through a window and striking him in the right lumbar region. The patient was brought to the hospital, and presented the appearance of considerable shock, with marked abdominal pain and rigidity. The abdominal findings were those of peritoneal injury with marked distention, tenderness and pain. The pulse was 100, temperature 99 F. The patient was prepared for operation and taken to the operating-room, but refused operation at that time, it being 2 o'clock in the morning. The following morning at 9 o'clock, the symptoms not having abated, the patient was again consulted and urged to submit to operation, to which he consented.

Operation.—The abdomen was opened in the middle line above the umbilicus, and the liver, gall-bladder, stomach, spleen and the intestines, were carefully gone over without finding any evidence of injury to them or any fluid or intestinal contents in the peritoneal cavity. A second incision was made below the umbilicus, and the abdominal contents examined through this incision, without finding any lesion. Examination of urine having been made without finding any blood or albumin, it was felt that the kidneys had escaped injury, and the abdomen was closed up, with drainage.

Subsequent Course.—The following day the patient developed a slight elevation of temperature and the temperature continued to increase on succeeding days, until he had a daily temperature of 101 F.

Physical examination of the chest revealed the pressure of fluid in the pleural cavity on the same side as the injury. The patient made a quick recovery from his laparotomy wounds. The findings in the chest cleared up after three weeks and the patient was discharged as cured.

The explanation of the clinical findings of injury to the peritoneal contents, I believe, lies in the fact that the diaphragmatic portion of the pleura was injured and infected, and the pain was transferred to the abdomen, as is so frequently observed in lower lobe pneumonia.

I believe that with the symptoms above enumerated, no surgeon would have been justified in leaving the abdomen unopened, and that we have no means at our command at the present time of discriminating between a wound of the pleura which produces abdominal symptoms, and a wound of the abdomen itself.

Sanitary Control of Public Milk-Supply.—"The importance of controlling the quality of the public milk-supply," says Prof. E. O. Jordan (*Science*, June 2, 1911), "although frequently urged by sanitarians, is not always appreciated. At the present time, in a great majority of American cities, it is safe to say that for every case of infectious disease due to drinking-water, ten cases are caused by infected milk. It is difficult to secure adequate funds for the sanitary control of the milk-supply. By sanitary control of milk is meant, not the upholding of a rigorous standard of butter-fat and total solids, but the maintenance of proper standards of cleanliness and health for dairy cows and especially the safeguarding the milk free from infection during collection and transportation. Under some conditions the protection of the consumer against milk-borne infection may be best brought about by compulsory pasteurization of that portion of the milk-supply which cannot otherwise be raised to proper standard. Whatever method of control may be adopted, it is certain that any genuine improvement in the character of a milk-supply will be followed in the long run by a lessening in the amount of typhoid fever and to some extent tuberculosis. The early detection of a single case of typhoid fever or scarlet fever on a dairy farm may be the means, not only of preventing an extensive epidemic, but of avoiding the formation of scores of new foci which can . . . light up subsequent cases for many years."

Therapeutics

CHOLERA INFANTUM; SUMMER DIARRHEA OF INFANTS

Probably both of the designations at the head of this article will soon be entirely banished from scientific nomenclature. At the present time, however, it is convenient to use them, even if they are not scientifically accurate, to indicate a class of diseases which are seen during the hot weeks of summer. It was formerly the custom to limit the use of the term "cholera infantum" to attacks of diarrhea with watery movements, accompanied by vomiting and great prostration, which came on suddenly, and often resulted in death. At the same time it was the custom with many physicians to apply the name to all cases of diarrhea with vomiting seen in young children, so that the accounts given by medical men of this trouble have been more or less inexact. Not properly included within this class are the very large number of cases of diarrhea in children which come on more or less gradually and which often are not so severe as the cases previously spoken of. In some of these cases, besides the diarrhea, vomiting is a prominent symptom. In other cases, vomiting is nearly or completely absent. The movements frequently contain blood, mucus, or pus, and are accompanied by pain and tenesmus. The former class of cases are commonly designated as acute gastro-enteritis, the latter as entero-colitis.

ETIOLOGY

Several factors are obviously concerned in the production of these diarrheal disorders. Formerly, the high temperature prevalent during the greater part of July and August was supposed to have an important influence in causing the disease. More recently, with the increasing attention paid to the study of bacteriology, and especially to the study of the so-called intestinal flora, a fermentation of the food, produced by the growth and development of the bacteria, is believed to be the most important element in the production of these diseases. Now, it is assumed by many that the deleterious influence of the high temperature of the summer is chiefly productive of disease by encouraging the fermentation and putrefaction of the different articles presented to the child as food, and particularly causing the growth and development of bacteria in milk, with the consequent fermentation and putrefaction and production of various sorts of toxins. The etiologic factor of disease, "cold or chilling," to which so much was formerly attributed in causing disease, has been almost forgotten. Few now stop to consider that possibly the chilling of the surface of the body, during cool nights, or by exposure to drafts, may so interfere with the normal processes of digestion as to produce a gastro-enteritis.

PROPHYLAXIS

It is impossible to overestimate the importance of properly instructing parents and care-takers how to feed infants and young children so that they may avoid attacks of these disastrous diseases. It is not necessary to stop here to discuss the desirability of feeding infants at the mother's breast until they are at least 6 months old, and perhaps a year old. The occurrence of diarrheal diseases in breast-fed infants is infrequent, and the mortality is very slight. A common grave mistake in the feeding of children under 2 years old is to give them everything which the adults of the family eat,

everything which they see and ask for, and in addition to this various candies and cakes which are presented to them, in addition to all the rest of the food which the family eats. It is not necessary to protest to medical men against this system of dietetics, but it is necessary to remind some of them that they should make it a point to protest to the parents against permitting the children such a miscellaneous variety of food. But even when intelligent mothers attempt to feed their children in a sanitary way, they find many pitfalls and obstacles in their path.

Perhaps the chief and the most important is the difficulty of securing suitable food. In the country, where every farmer has his own cows, and where every resident is not far distant from a farm, it is a matter of only a little trouble to get fresh milk immediately after the morning and evening milking. This is the ideal food-supply. Children who are so fortunately circumstanced that they can obtain food of this kind have little excuse for suffering from diarrhea in summer. If milk, as soon as it is taken from the cow, is subjected to a temperature of 40 or perhaps 45 F., the growth of bacteria is inhibited, and if the milk is kept continually at this temperature it may be preserved without becoming damaged much longer than when it is allowed to stand in the ordinary temperature of the air.

When milk is brought to small cities from farms in the immediate neighborhood, the dairyman frequently places the milk in quart bottles as soon as it is cooled, and keeps it cool until it is delivered to the consumers. This is the ideal method of handling milk, but only a small portion of milk is handled in this way.

It is necessary for the physician to impress on the mind of the parent the importance of using every effort to get a good supply of milk which is as fresh as possible, and which has been carefully handled. In the opinion of most physicians who have given the subject careful study, no other food is as desirable for a child under one year of age, who is deprived of its mother's milk, as fresh cow's milk.

The recognition of the difficulty of securing fresh milk, or milk which has been properly cooled and preserved, led, some years ago, to the introduction of sterilized milk as a food for infants. It did not take very long to demonstrate that this was not a satisfactory food for general and prolonged use in infant-feeding. Next it was proposed not to sterilize it by boiling, but to pasteurize it by subjecting the milk to a lower temperature than was necessary for complete sterilization. It is to be noted that this process, while it inhibits the development of bacteria, does not prevent the growth of spores and does not destroy the toxins which have been already produced in the milk. While it is very much the fashion at the present day among physicians and charitably inclined women to advocate pasteurization of the milk, there seem good reasons for believing that while perhaps pasteurization as a temporary expedient may not be an unmixed evil, still there are so many and such serious objections to its use that it should not be generally recommended. Not only does it fail to destroy the spores and toxins in the milk, but there are reasons for believing that it produces dissociation of the mineral and protein elements of the milk so that they do not fulfil the nutritive function in the body of the child as do the same ingredients of unchanged milk.

Equally important with the food-supply to the young child is the air with which he is surrounded and which he breathes. An attempt must be made to give as much fresh air as possible to the large number of poor children, who can neither be taken to the mountains nor to the seashore, but who must continue to spend the entire season in a tenement house in a crowded district. They should be taken out of the houses, into the parks, or, if they live in a seaport town, taken to the edge of the harbor or to the bank of the river. When they are at home, they should, if possible, be kept on the roof or piazza, and when this is impracticable, the windows should be opened so that the fresh air will circulate through the house. At the same time, the child, when out of doors, should be kept out of the sun, and when indoors should be protected from drafts.

TREATMENT

It is impossible to lay down any routine treatment to apply in all cases of infantile diarrhea. Success requires the exercise of the physician's best judgment and common sense. First, it may be mentioned that the child should be kept as much as possible in cool, fresh air, and should be kept quiet. Carrying the patient about or shaking him, as children are so often shaken and jumped, will increase the movements of the bowels. On the other hand, if he is kept absolutely quiet and comfortable, his bowels move less frequently. If he has considerable fever, he should be bathed with tepid or cool water, at intervals of three or four hours. Although he must be in a cool room, he should be protected from direct drafts through windows or doors.

Under the present belief of the very great importance of the part played by bacteria in producing these diarrheal disorders, most teachers of the present day advise initiating the treatment by the administration of a cathartic or laxative, with the idea of clearing out from the intestinal tract the fermenting food and the bacteria which are causing fermentation. Probably castor oil is the most useful drug which can be given for this purpose. To a child 6 months old half a teaspoonful may be given, to one a year old, a teaspoonful, and to one 2 years old, two teaspoonfuls. Nothing else should be taken into the stomach within two hours either before or after the oil is administered. If the first dose is vomited, a second should be given after one hour. If, on account of excessive vomiting, or for any other reason, it seems wise to give some other cathartic than castor oil, a teaspoonful of aromatic syrup of rhubarb may be given. This does not act so quickly as the castor oil, but like the latter, has the advantage of having its action followed by a constipating effect. Many prefer small doses of calomel to either castor oil or rhubarb. An eighth or one-tenth of a grain of calomel may be given at intervals of half an hour, until a grain has been taken.

The physician who is called to a little child who has had a number of copious watery movements in rapid succession, and who has vomited several times while the diarrhea has been going on, may decide that the stomach and bowels are sufficiently emptied, and may commence the treatment by giving sedatives without the preliminary cathartic. Drugs of this kind will be discussed later.

After a cathartic has been given and has acted, it is advised that all food should be withheld for at least twenty-four hours. A small amount of water may, however, be given at more or less frequent intervals. The patient usually suffers very much from thirst, and it is necessary to administer some fluid by the mouth to quiet his restlessness and fretfulness. If the vomiting continues after a cathartic has been administered, often a little hot water placed on the tongue will stop

it. The water should be given in such quantities as experience in the case shows are suitable, beginning with a quarter or a half teaspoonful at intervals of fifteen minutes or half an hour. If this amount is tolerated, it may be gradually increased so that the patient will take from a teaspoonful to a tablespoonful at intervals of one or two hours.

At the end of twenty-four hours, if the stomach is settled and the patient is free from pain, and the character of the movements is improved, food in small amounts may be commenced. In most cases nothing is better than small quantities of milk properly diluted. This dilution will be made according to the experience of the individual doctor in infant-feeding. Barley-water has long been a favorite diluent for milk, and one may try a teaspoonful of the top of a bottle of milk diluted with six or eight parts of barley-water. A small amount of this may be given, depending on the success with which it is retained. If the child retains a small quantity, at subsequent feedings the quantity may be increased until he takes a sufficient amount to fill his stomach. This being retained, the strength of the milk may be increased until he takes it of the strength adapted to his age.

In most of these cases the digestive power of the child is more or less impaired, and this suggests the desirability of predigesting the milk before it is given to him.

A great variety of especially prepared foods have been suggested for young children, and have been advised as of special use in children suffering from indigestion and diarrhea; but the tendency of the present day is to consider these all inferior to fresh milk. The same may be said of various broths, gruels and meat-juices which have from time to time been recommended by various writers. One substitute for fresh milk should, however, be mentioned, and will perhaps sometimes be found useful in emergencies such as when, for any reason, fresh milk cannot be obtained, or when, owing to the great heat, the supply on hand becomes spoiled. This substitute is condensed milk. This came into great popularity in certain large cities because men who practiced among the poor experienced difficulty in obtaining fresh milk, and found that the children throve when given condensed milk. Even now when good milk cannot be obtained, or when it is found that the child does not digest the milk provided for him, condensed milk may occasionally be tried and will not infrequently be found to give satisfaction. Its use, however, should not be indefinitely continued, for children who are fed on it alone for long periods of time are likely to contract scurvy.

While the hygienic and dietetic management of these diarrheal diseases is of the very greatest importance, the medicinal treatment should not by any means be neglected. It has been mentioned that in some cases it may seem proper to commence the treatment of this disorder by sedative medicines, without a preliminary cathartic. The best and the most useful gastro-intestinal sedative which we have is the subcarbonate of bismuth. This may be given in doses of from 0.30 to 1 or even 2 gm. (5 to 15, or even 30 grains). It frequently checks the vomiting, and has a favorable influence over the intestinal movements. It is often of benefit to add a small dose of phenyl salicylate (salol), a bowel antiseptic, to each dose of bismuth.

Next in importance and value to bismuth stands opium. While many physicians condemn the use of opium in these disorders, probably every physician who has much practice among children is often compelled to use it to save his patient. The best preparation of opium for use with children is the tincture of deodorized opium. Of this one drop may be given to a child one year old, and this dose may be repeated every two, three or four hours, if the child is in pain, or if he is not asleep.

In some cases it is desirable to give some of the digestive ferments in order to promote the digestion of food. A palatable essence of pepsin will often be found useful.

If the vomited matter or the stools are sour, the bicarbonate of sodium may be given with a carminative. For instance:

℞	Gm. or c.c.		
Sodii bicarbonatis	2		3ss
Spiritus menthæ piperitæ	2	or	fl.3ss
Syrupi	25		fl.3i
Aquæ	ad 100		ad fl.3iv

M. et Sig.—Give 1 teaspoonful, every two hours, in a little hot water.

In cases which are severe from the beginning, if there is much pain, with frequent copious watery movements, a hypodermatic injection of 1/100 of a grain of sulphate of morphin with 1/1000 of a grain of sulphate of atropin may be administered. If this dose is found to be too small, a larger dose may be given. By stopping the pain, by quieting the intestinal movements and the general restlessness, and perhaps by producing sleep, this will often do the little patient a great deal of good.

After the disease has continued for several days, if the heart becomes weak, brandy may be administered in doses of from 10 to 20 drops for a child one year old.

During recent years the use of buttermilk in diarrheal affections has found many advocates. Investigation of the bacteria found in the intestine in health and in disease has shown that the bacteria which are present in health disappear and their places are taken by other bacteria during the presence of diarrhea. It has been found that these diarrheal bacteria have their action inhibited by certain strains of lactic acid bacteria. There are a great variety of these lactic acid bacteria, perhaps twenty-five or more, and not all strains of the lactic acid bacteria are equally efficient against the pathogenic bacteria. But practically certain efficient strains have been found and have been cultivated, and these should be used when the treatment by buttermilk is to be undertaken. It has been customary in a great many places to pasteurize the buttermilk before it is given to the child, but this, of course, entirely nullifies any action of the lactic acid bacteria, and either fresh buttermilk should be given unpasteurized, or, if the pasteurized product is used, it should be freshly inoculated with an efficient strain of the lactic acid bacteria; otherwise no beneficial action can be expected.

The administration of lactic acid bacteria is not equally effective in all sorts of diarrheal troubles, but it has been found that they are especially useful in that class of cases which are termed "fermental" diarrhea. Clinically these cases are characterized by diarrhea which, as a rule, comes on suddenly. The movements are loose and watery, usually green in color, and with a foul or sour odor. The mucus, blood and pus which are usually present in enterocolitis are usually absent in this condition. The temperature may be elevated for a day or two, but this does not persist. Vomiting is common, and abdominal pain is present, but tenesmus is not. In cases such as these, the administration of buttermilk containing lactic acid bacilli will often prove very beneficial.

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SATURDAY, JULY 1, 1911

RESTRICTION OF THE SALE OF HABIT-FORMING DRUGS

The Boylan bill to prohibit the sale of hypodermic syringes or needles at retail without an order from a physician or veterinary, which passed the New York legislature some time ago, has been signed by the governor and is now a law. This measure is an effort on the part of the State of New York to control the growing use of morphin and cocain. Commenting on this bill the *Outlook* said editorially: "It seems incredible that there should be objection on the part of any intelligent person to the passage of such a measure. . . . It is beyond doubt that the availability of the hypodermic syringe has been as much a factor in the wide-spread use of morphin, cocain, etc., as the availability of the drugs themselves and that the vast majority of hypodermic syringes and needles are used to give morphin and cocain in a harmful way. The objection is made that drug fiends could easily obtain syringes and needles through the mails from druggists in another state. This is perfectly true and is, of course, the weak point in all state legislation designed to control the use of habit-forming drugs and instruments for their injection. If New York State will lead the way in this reform, however, there is little doubt that other states will follow so good an example. At all events, the lower grade of drug and department stores of New York and elsewhere would be deprived of one of their activities. . . . If the laity is buying hypodermic outfits we may, we think, rest assured that it is for the harmful injection of morphin and cocain."

The statement made by the *Outlook*, that hypodermic syringes and harmful drugs can be sent through the mails from other states having no restrictive laws, can and should be met by appropriate federal legislation prohibiting interstate commerce in hypodermic syringes, needles and habit-forming drugs, except by responsible and properly authorized persons. The suppression of traffic in these drugs for vicious purposes will probably necessitate the adoption of some restrictions and regulations on the part of physicians. For instance, in the bill introduced two years ago in congress, by Mr. Mann, intended for the suppression of interstate commerce in morphin and cocain, it was provided that physicians ordering such drugs from pharmaceutical houses outside of their own state must be registered with the federal authorities and must keep a record of the amount of such drugs ordered and the manner of their disposal. As was to be expected, this proposition brought out indignant protests from pharmaceutical mail-order houses and others who asserted that it was an infringement on the rights of the dispensing physician. To this cry was added the usual stock argument that the proposed legislation was inspired by a drug syndicate for the purpose of preventing dispensing by physicians. As a matter of fact, Mr. Mann's bill was drafted in accordance with the recommendations of the International Opium Conference held at The Hague and composed of representatives of the various nations interested in the suppression of the opium traffic.

Custom-house records show that the importations of opium and cocain into this country vastly exceed the amount required by physicians for legitimate purposes. Beyond question, the surplus is used for the gratification of drug habitués and the creation of new victims. The repression of this horrible traffic can be accomplished only by rigid regulation of the legitimate trade, for which a careful record of all sales and purchases of such drugs is essential. If such regulation imposes some inconveniences on our profession, it must be accepted as a part of our duty to the state and to the public. We must recognize the fact that the right to use dangerous drugs for saving life as a corollary carries with it an obligation to prevent the improper or harmful use of such drugs and that it is quite as important a duty of physicians to see that no person secures morphin or cocain who does not need it as it is to see that patients who are in need of the beneficent effects of such a drug are given the benefit of it. We congratulate New York on having been the first to pass such a bill and hope that her example will be speedily followed by all other states.

MEDICAL HISTORY CLUBS

A favorite statement of continental European writers is to the effect that the average English and American physician is often lacking in a proper interest in the history of his subject, the reason usually assigned being the intensely practical nature of the English-speaking practitioner, which allows him neither the time nor the inclination to approach his specialty from the historical side. While much of the best historical work in the past has undoubtedly been done by French and German scholars, like Littré and Daremberg, Choulant or Pagel, yet such exhaustive recent monographs as those of Adams, Greenhill, Payne, Norman Moore, D'Arcy Power, Osler, Sir Clifford Allbutt, Finlayson, Billings or Weir Mitchell have gone far to lift this imputation of late years. For the practitioner who writes, the advantage of a proper study of "origins" is, of course, self-evident. Much superfluous controversy, much waste

of the writer's (and reader's) time and of a journal's space, might be saved if physicians investigating a subject always knew exactly what others had done before them.

A proper interest in the historical side of medicine might easily be stimulated by means of short courses in medical history for students before graduation or by the formation of medical history clubs among practitioners themselves. As such clubs are usually made up of kindred spirits, the membership of any is not likely to be too large, which has the double advantage of giving every one a frequent chance to read papers and of avoiding unnecessary repetition in discussions. As an example of what can be accomplished in this field we may instance the remarkable work of the Historical Club of the Johns Hopkins Hospital, which was organized in November, 1890, beginning with exhibitions of rare medical classics by Drs. Billings, Osler, Kelly and others, and which has since turned out so many fine papers, published in the *Bulletin of the Johns Hopkins Hospital.*

Another prominent medical history club, the Charaka Club of New York City, organized in 1898, consists of eighteen members and has already published three handsome volumes of transactions, which have been reviewed in these columns. Among the subjects treated were "Greek Medical Fees," "The Evil Spoken of Physicians," "The Cult of Æsculapius," "Antonius Musa," "Fracastorius," "Shakespeare's Last Illness," "The King's Touch for Scrofula," "Dutch Physicians in New Amsterdam," "Garth's Dispensary" and "Flaubert's Epilepsy"; and the proceedings have been enlivened by original poems, little plays, novelettes and facetiæ by the different members.

The Medical History Club of Washington, D. C. was founded in 1908, and prints its transactions in the *Old Dominion Medical Journal.* During the present year interesting papers on Auenbrugger, Pasteur and Bichat and "Casserius and Anatomic Illustration" were read. Practitioners of the town and country will find relaxation from the cares of their busy lives in little coteries of this kind and their papers will lend variety and interest to the journals and transactions of their respective medical organizations.

THE PRESIDENT AND THE FOOD AND DRUGS ACT

We have, for the past three weeks, called attention to the failure of the federal Food and Drugs Act, under the interpretation recently given it by the Supreme Court, to protect the public against loss both in health and pocket from lying claims regarding the curative effects of nostrums. As soon as the new interpretation became public, some of the more progressive members of Congress began to plan for getting an amendment to the pure food law that would specifically prohibit untruthful claims for therapeutic effects of drugs. President Taft, on June 21, took official cognizance of the blow that the Supreme Court decision had dealt the Food and Drugs Act by sending a special message to Congress urging the very amendments that are needed to restore that law to its previous efficiency. Said the President:

"An evil which menaces the general health of the people strikes at the life of the nation. In my opinion . . . the sale of drugs under knowingly false claims as to their effect in disease constitutes an evil and warrants me in calling the matter to the attention of the Congress.

"Fraudulent misrepresentations of the curative value of nostrums not only operate to defraud purchasers, but are a distinct menace to the public health. There are none so credulous as sufferers from disease. The need is urgent for legislation which will prevent the raising of false hopes of speedy cures of serious ailments by misstatements of the fact as to worthless mixtures on which the sick will rely while their diseases progress unchecked."

To meet the objection that has been raised in some quarters that the curative effect of nostrums is a matter of opinion and not of fact and that the opinion will vary both as regards the so-called schools of medicine and also as to individuals of the same school, Mr. Taft says:

"No physician of standing in his profession, no matter to what school of medicine he may belong, entertains the slightest idea that any of these preparations will work the wonders promised on the labels."

And further:

"Of course, as pointed out by the Supreme Court, any attempt to legislate against mere expressions of opinion would be abortive; nevertheless, if knowingly false misstatements of fact as to the effect of the preparations be provided against, the greater part of the evil will be subject to control."

That the amendment suggested by the President will be fought by the "patent medicine" interests is to be expected. The Proprietary Association, as recently as June 17, sent out a letter purporting to give "the legal aspect of the Johnson case." The gist of the letter is contained in the following sentence that appears in it:

"As there is no science in therapeutics, the practice of medicine being based on opinion and not on definite scientific facts—any statement concerning the curative properties of any drug, chemical or medicine, is largely a 'matter of opinion' . . ."

In the opinion of the Proprietary Association—in other words, in the opinion of "patent medicine" makers—"the effect of the decision of the Supreme Court does not change or weaken the Food and Drugs Act in any particular."

President Taft, as evidenced by his special message, disagrees with the "patent medicine" men, for in his message he says:

"I fear that if no remedial legislation be granted at this session the good which has already been accomplished in regard to these nostrums will be undone, and the people of the country will be deprived of a powerful safeguard against dangerous fraud."

We believe that the restrictions the President would have placed on the nostrum business are more likely to meet with public approval than the "wide-open" policy advocated by the makers of "patent medicines." Amend the act!

Current Comment

THE MILWAUKEE WATER-SUPPLY

About a year ago[1] a report by our special commissioner appeared in THE JOURNAL dealing with the relation between typhoid fever in Milwaukee and the water-supply. In that report the opinion was expressed that the excessive prevalence of typhoid fever in Milwaukee was chiefly due to a contamination of the public drinking-water with sewage. The conclusions then expressed have been fully confirmed by the report of a commission of well-known sanitary engineers which has been just submitted to the Milwaukee Common Council. The work of the commission, which has extended over more than two years, has led to several important recommendations. Immediate filtration of the water-supply is advised, with disinfection when necessary, this recommendation being based on the observation that "the waters of the bay are polluted by the sewage of the city and at times the water supply is contaminated." In accordance with the best practice the report advises that sewage purification be undertaken only to the extent necessary to prevent undue contamination of the rivers and bay. Specific recommendations are made concerning the installation of flushing works, intercepting sewers and trickling filters. If expert advice of this sort is followed, water-borne typhoid fever in Milwaukee will quickly disappear.

DIPHTHERIA AND MILK IN MINNEAPOLIS

The recent epidemic of diphtheria among the students and faculty of the University of Minnesota, which originated in one of the dairies supplying milk to the section of Minneapolis in which many of these persons resided, emphasizes several points regarding the transmission of infectious diseases. The human carrier of these infections is being found constantly to bear a wider responsibility in this respect, and the problem of eradicating many infectious diseases resolves itself into one of making human bacillus-carriers as harmless as possible. This is true of yellow fever, of malaria, of sleeping-sickness, of typhoid and of diphtheria. As a secondary medium of contagion probably no single substance occupies a more important rôle than milk, and the difficulties of removing all possibility of infection through this source are brought out forcibly in this Minneapolis epidemic of diphtheria. In line with the strenuous campaign for clean milk, which is now well-nigh universal, Minneapolis has adopted stringent regulations regarding the production and handling of milk and the measures have been fairly well carried out. It was found, however, that the source of the infection in this epidemic was one of the cleanest and best regulated dairies in the Minneapolis district. Almost ideal conditions obtained in the dairy, and the personnel seemed to be unobjectionable. The epidemic was traced to this source notwithstanding and the application of scientific methods in taking cultures from the throats of every employee revealed the fact that one, a man who handled the milk, though appearing well himself, was a carrier of the diphtheria bacillus. Prompt measures, including the isolation of the carrier, the destruction of the milk which this man had handled, the sterilization of all the utensils, the examining and quarantining of every person exposed to the infection and the disinfection of houses and schoolrooms promptly checked the epidemic; not, however, until twenty-two cases of diphtheria had developed. This instance illustrates the tremendous difficulty of absolutely ruling out all sources of contamination of the milk-supply, but it also illustrates the correct scientific method of getting at the origin of infections and of handling them promptly.

1. Typhoid Fever in Milwaukee and the Water-Supply, THE JOURNAL, July 16, 1910, p. 211

MISREPRESENTATION A WEAPON OF THE REACTIONARIES

One of the most important bills passed during the recent legislative season was Senate Bill 451, passed by the Arkansas legislature, creating a state department of health. This bill was opposed from the time of its introduction by the representatives of the National League of Medical Freedom, and the usual misstatements and stock editorials appeared in all the newspapers in the state which the interests behind this organization could control. One of the newspapers of Fort Smith published a stereotyped editorial which, with a few alterations, has been made to do service in many other states, opposing the passage of this bill and the establishment of a department of health by the state. The editorial contained an extract from the much-quoted paper of Dr. Samuel G. Dixon[1] which appeared in THE JOURNAL several years ago, but, in addition to the extract from Dr. Dixon's article, the following appeared as a part of the quotation: "The faithful allies, the physicians of the commonwealth are, of course, only those physicians who belong to and are in good standing in the state and county associations." As soon as this editorial appeared, one of the local members of the Association called the attention of the editor to the fact that this sentence did not appear in the paper as published in THE JOURNAL or in the printed record of the meeting, and that it has been interpolated without authority. Accordingly, in a subsequent issue the editor acknowledged the inaccuracy of the quotation and withdrew the interpolated sentence. The editorial in question is a fair sample of the methods followed by the organized interests which are opposing the forward movement in public health legislation. It would be well to scrutinize carefully the publications, pamphlets, and especially the "canned editorials" which are appearing in such quantities in the newspapers, in order to prevent further misrepresentation and distortion of facts.

SUICIDE REPORTS IN THE PRESS

The American Academy of Medicine, in cooperation with the American Medical Association, took action last year condemning the publication of details of suicides in the public press, and the former organization appointed a committee for the purpose of investigation along these lines. In an advance report[2] of the committee, now at

1. Dixon, Samuel G.: Law, The Foundation of State Medicine, THE JOURNAL A. M. A., June 8, 1907, p. 1926.
2. Presented at Los Angeles, June 24, 1911.

hand, this attitude of the press is characterized as criminal. The evidence that the suggestive effect of reading details of suicides is a partial cause of this crime among susceptible persons unfortunately cannot be reduced to a mathematical demonstration. Statistics can show only by presumption the importance of this influence, which, however, is pronounced to be obvious by those who have had to deal with such persons. The committee believes that legislative steps to prevent publication of this class of news must be preceded by popular education. For this purpose the following suggestions are offered: 1. The coroners in large cities should keep data showing (a) dates of prominent publication of details and methods of suicides, (b) dates of subsequent suicides, grouping the cases by methods, (c) direct evidence obtained by investigation at inquests. 2. The papers should refrain from publishing such news for a month, and then all should simultaneously publish prominently an account of one such case. Again they should refrain from such publication for a month; meanwhile accurate records of cases and methods should be kept. If the results indicate a direct relationship, the publication of such news should be recognized as criminal. This would be animal experimentation on a large scale. The cooperation of the press could make possible some valuable deductions. The work of this committee will form weighty evidence as to the influence of the American press of to-day.

THE LOS ANGELES SESSION

According to telegraphic advices, the Sixty-Second Annual Session of the American Medical Association, held in Los Angeles, California, during the past week, has been a remarkably successful one in every respect. While the distance from the center of population was great and deterred many who otherwise might have been present, nevertheless, on Tuesday night 2,024 had registered—an unusual number when the location is considered. It is not too much to estimate that between 2,500 and 3,000 will be the total registration—perhaps more. It is probable that the larger proportion of the arrivals at this session are early in the week because there is not a very populous section of country in the vicinity from which members are apt to come after the opening of the session. A large number of ladies accompanied the members, as the attendance at the meeting is being made the occasion for a summer outing. Many special trains were sent to the meeting, and a common topic of discussion was what route to take on the return trip and how many different attractions of the western country could be seen. The entertainments provided by the local Committee on Arrangements seem to have been on a more splendid scale than at any meeting heretofore held. The reputation of California for hospitality has been increased by the treatment of the visitors at the Los Angeles session. Commencing on page 57 of this issue, THE JOURNAL devotes thirty-two pages to the official minutes of the House of Delegates, entirely covering its first and second meetings, Monday morning and afternoon, June 26, except for three small reports near the end. The minutes will be continued in THE JOURNAL next week. The Address of the President, Dr. John B. Murphy, delivered before the General Meeting Tuesday morning, appears as the leading article in this issue of THE JOURNAL. The publication of Section papers and discussions will begin next week, July 8. The character of the scientific proceedings is not behind that of other years. Some programs did not contain so many papers and thus more time was saved for discussion, which is always a valuable feature. The Sixty-Second Annual Session is thus a success in every way and an occasion of pleasure and profit to those so fortunate as to be able to attend it.

Medical News

CONNECTICUT

State Society Meeting.—The 119th annual meeting of the Connecticut State Medical Society was held at Hartford, May 24-25. The following officers were elected: president, Dr. John G. Stanton, New London; vice-presidents, Drs. D. Chester Brown, Danbury, and Robert C. Paine, Thompson; secretary, Dr. Walter R. Steiner, Hartford, and treasurer, Dr. Joseph H. Townsend, New Haven. The society will hold its next annual meeting at New Haven, May 22-23, 1912.

ILLINOIS

Another County Bulletin.—The Williamson County Medical Society has commenced the publication of a little four-page bulletin called the *Williamson County Physician*. It contains some constructive editorial matter, announcements of the next meeting of the society, some personal news items, and some advertisements.

State Board of Health Appropriations.—The appropriations of the State Board of Health for sanitary purposes were increased by the general assembly just adjourned. The sum of $46,000 was given for the purchase and free distribution of diphtheria antitoxin in the state. An appropriation was also made for the care of poor persons bitten by rabid animals. Liberal appropriations were made for the enforcement of the medical practice act, to take the place of the fees turned in under the new law. Unfortunately, it is specified in this appropriation that no part of this sum shall be expended for legal services.

State Board of Health Handicapped in Prosecutions.—The recently enacted law, in effect July 1, requiring the State Board of Health to turn into the state treasury all moneys received from fees, fines and penalties, leaves the board without means to hire special attorneys to prosecute violators of the medical practice act in the several counties of the state. Suits must be brought hereafter through state's attorneys, few of whom instituted prosecutions in the past even when paid the fines collected. The State Board of Health fears that under the present conditions, the state will be overrun with unlicensed practitioners, who will practice in defiance of the law.

Chicago

Chicago Society Election.—Chicago Medical Society recently elected the following officers: President, Dr. Joseph M. Patton; secretary, Dr. George F. Suker; councilors, Drs. Charles E. Humiston, Frederick Tice, Frank Billings, Hugh T. Patrick and Edward M. Brown.

Personal.—Dr. Henry G. W. Reinhardt, coroner's physician, has resigned to become statistician of the Cook County Hospital. He will be succeeded by Dr. Edwin R. LeCount, professor of pathology at Rush Medical College.——Dr. John E. Siebel, Jr., will sail for Europe soon.

LOUISIANA

Parish Society Reorganized.—The physicians of Vernon Parish met at Leesville, May 17, and reorganized the Vernon Parish Medical Association, electing Dr. Finas P. Jones, Leesville, president; Dr. N. M. Palmer, Fullerton, vice-president, and Dr. M. R. McAlpin, secretary-treasurer.

Personal.—Drs. Benjamin H. Talbott and Joseph H. Pankey have been appointed members of the Board of Health of Dodson.——Dr. Hugo A. Gabert, New Orleans, on the occasion of the twenty-fifth anniversary of his entrance into the profession, was given a silver service by the Firemen's Charitable and Benevolent Association.——Dr. K. Winfield Ney, Madisonville, has leased the Hammond Sanitarium.

Election of Medical Club.—At a meeting of the Physicians' and Surgeons' Club of Shreveport, May 23, it was decided that the club should be continued and it was recommended that the name be changed to The Academy of Medicine. The following officers were elected: president, Dr. William K. Sutherlin; vice presidents, Drs. Joseph E. Knighton, C. Pearl Munday and Thomas F. Long, and secretary and treasurer, Dr. P. W. Oden.

MAINE

Society Meetings.—The physicians of Sanford and Springvale met recently and organized the Sanford Medical Society, electing Dr. Charles W. Blagden, president; Dr. W. H. Kelly, secretary, and Dr. Ernest L. Burnham, treasurer.——At the annual meeting of Somerset County Medical Society, held in Skowhegan, the following officers were elected: president, Dr. Leander A. Dascombe, Skowhegan; vice-president, Dr. Walter S. Milliken, Madison; secretary, Dr. Harry W. Smith, Norridgewock; delegate to the Maine Medical Association, Dr. F. S. Merrow, Norridgewock, and censors, Drs. Walter S. Stinchfield, John E. Wadsworth, Showhegan, and Justin D. Ames, Norridgewock.

MARYLAND

Baltimore

Personal.—Dr. Alexius W. McGlannan received the degree of M. A. at the commencement of Rock Hill College, Ellicott City, June 16.——Dr. George Heller is reported to be seriously ill with rheumatism.——Dr. Albertus Cotton has received the degree of A.M. from Ohio University.——Drs. Frederick Taylor, Herbert M. Evans, Lillian Welsh and Mary Sherwood have sailed for Europe.——Dr. Albert H. Carroll will spend the summer at Woods Hole, Mass., in research work.——Dr. Gordon Wilson has been appointed a member of the board of managers of the Maryland Tuberculosis Sanatorium.——Drs. J. Conrad Uhlig, Joseph E. Gichner, L. R. Klemm and William W. Ford have sailed for Europe.

Johns Hopkins Commencement.—At the commencement exercises of Johns Hopkins University, June 13, a class of eighty-four received the degree of M.D. The following announcements were made of changes in the medical faculty: Dr. Thomas R. Boggs was made associate professor of medicine; Charles D. Snyder, Ph.D., associate professor of physiology; Dr. Frank J. Sladen, associate in medicine; William E. Burge, Ph.D., instructor in physiology; Dr. Karl M. Wilson, instructor in obstetrics; Dr. Solon A. Dodds, assistant in obstetrics; Eli K. Marshall, Jr., Ph.D., assistant in physiologic chemistry; Dr. Isaac R. Pels, assistant in dermatology, and Dr. Maxwell Ross, assistant in medicine.

MASSACHUSETTS

Massachusetts Medical Society.—The 130th annual session of the Massachusetts Medical Society was held at Boston, June 13-14, and the following officers were elected: president, Dr. George B. Shattuck, Boston; vice-president, Dr. Ernest S. Jack, Melrose; secretary, Dr. Walter L. Burrage, Boston; and treasurer, Dr. Edward M. Buckingham, Boston. The next meeting will be held at Boston in June, 1912.

Personal.—Dr. Henry E. Doonan, South Hadley Falls, has been appointed associate medical examiner for the Third Hampshire County District, vice Dr. David E. Harriman, term expired.——Dr. John H. C. Gallagher, Chicopee Falls, has been appointed medical examiner of the Fifth Hampden District.——Dr. Frederick H. Thompson has been chosen as school physician of Fitchburg.——Dr. John F. Sullivan has been appointed school physician of Boston.

MINNESOTA

Personal.—Dr. Hibbert Winslow Hill, director of the division of epidemiology of the Minnesota State Board of Health, received the diploma of public health from the University of Toronto, June 9.——Dr. Arthur W. Shaleen, Hallock, has returned from Europe.

Society Merger Favored.—The Minnesota Valley Medical Association, at its recent meeting in Mankato, voted unanimously in favor of forming a union with the Southern Minnesota Medical Association and appointed a committee to carry on negotiations to bring about this result. The Southern Minnesota Medical Association will act on the matter at its meeting in August.

NEW JERSEY

New Building for Sanatorium.—The budget of the city of Newark contains an item of $10,000 for the erection of a shack for the accommodation of patients on the sanatorium grounds at Verona, to accommodate thirty patients.

New Quarters for Academy.—The newly organized Academy of Medicine of Northern New Jersey took possession of its new quarters on the tenth floor of the Wiss Building, Newark, June 1. The academy occupies a half floor of the building and has accommodations for a laboratory, assembly room and office.

Building at Epileptic Village.—The contract for the erection of a building to be used for the treatment of feeble-minded men at the New Jersey Village for Epileptics, Skillman, has been awarded. The building is to cost $37,810.——An exhibition of the work done by the patients at the state village for epileptics was held in Newark, June 3, and on that day the institution was thrown open to the public for inspection.

Sanitarium for Treatment of Surgical Tuberculosis.—The North American Children's Sanitarium for the Treatment of Surgical Tuberculosis, Atlantic City, N. J., the direct successor of the North American Sanitarium for Convalescent Children, is about ready for the reception of patients. The sanitarium will be under the direction of an executive committee composed of Drs. H. Augustus Wilson, John B. Carnett and William L. Rodman of Philadelphia.

NEW YORK

For Flushing Hospital.—A benefit recently given netted $10,000 which is to be used for the erection of a new hospital for Flushing, L. I.

For Mount Vernon Hospital.—A twelve-day subscription campaign for the benefit of the building department of the Mount Vernon Hospital has resulted in pledges amounting to $75,000.

A Site for a Tuberculosis Hospital for Yonkers.—This city has received a gift of 5 acres of land as a site for a tuberculosis hospital from Alexander Smith Cochran. The common council will be asked to appropriate $50,000 for a building.

Personal.—Dr. Charles W. Webb, bacteriologist of the Clifton Springs Sanatorium, has been appointed bacteriologist of Ontario County.——Dr. Charles S. Allen, one of the oldest practitioners of Rensselaer, celebrated his 87th birthday, June 8.

New York City

Off for Europe.—The following have sailed for Europe: Dr. and Mrs. Theodore C. Janeway, Dr. and Mrs. Nathan E. Brill, Dr. William C. Lusk and Dr. and Mrs. Emery J. Thomas.

Addition to Minturn Hospital.—Plans have been filed for an additional story to the scarlet fever pavilion of Minturn Hospital at the foot of East Sixteenth Street, to cost $12,000.

German Bacteriologist Visits New York.—Dr. Erich Martini, a noted German bacteriologist who has been studying the bubonic plague in the far East for several years, and who has recently been visiting in New York City, has returned to Germany.

Local Medical Society Election.—At the annual meeting of the Harlem Medical Association, Dr. Thomas F. Reilly was elected president; Dr. Carl Goldmark, vice-president; Dr. Frederick C. Heckel, secretary; Dr. Seymour Oppenheimer, treasurer, and Drs. Frank C. Yeomans, John Remer and Martin Cohen, trustees.

Personal.—Dr. and Mrs. J. Wilford Allen, Dr. and Mrs. John D. Quackenbos and Dr. and Mrs. John Howland sailed for Europe.——Dr. Samuel B. Lyon, after fifteen years' service as superintendent of the Bloomingdale Asylum, will resign on July 1.——Dr. Charles S. Percival was rescued from a New Mexico desert recently by Capt. C. C. Farmer, Fourth U. S. Cavalry, and reached El Paso, June 11.——Dr. C. H. Chetwood received the honorary degree of LL.D. from Fordham University, at its commencement exercises, June 14.

Death-Rate Breaks Record.—Not in the history of the department of health has the death-rate for any one week been lower than for the week that ended June 11. There were 1,224 deaths from all causes recorded in the greater city compared with 1,389 for the corresponding week of last year, or 12.81 per cent. as against 15.81 per cent. in 1910. The death-rate from typhoid fever was the lowest that it had been in the last five years, there being five deaths as compared with ten of the previous year, and there were 385 deaths of children under 5 years as against 435 last year.

Cornell Commencement.—At the commencement exercises of Cornell University Medical College, June 14, a class of fifty-five was graduated. The John Metcalfe Polk memorial prizes were awarded to Helen Dudley, Elvira Dudley Dean and Wesley Manning Baldwin. Dr. Baldwin is to continue his studies in anatomy abroad during the coming year. The prizes in otology were given to Dr. Arthur William Justin and James

Edward McCormick. At a special meeting of the faculty, held prior to the commencement exercises, a set of engrossed resolutions was presented to Prof. Rudolph A. Witthaus, commemorating his years of distinguished service in the institution and expressing the regret of the faculty for his voluntary retirement from the chair of chemistry, toxicology and medical jurisprudence, which he has held since the college was opened. The dean expressed his satisfaction at the fact that Professor Witthaus would still retain a close connection with the college as professor emeritus.

OHIO

Personal.—Dr. Chalmers D. Morgan, Galion, has returned from Europe and is now located at Columbus.——Dr. Charles Barnsdall Parker, Cleveland, has received the honorary degree of Master of Science from the Ohio Wesleyan Medical School. ——Dr. Fred L. Watkins, Columbus, registrar of the State Bureau of Vital Statistics, has handed in his resignation to Secretary of State Graves.——Dr. Frank H. Yarnell, West Lafayette, is suffering from blood poisoning in the hand as the result of a rusty nail scratch; although his condition is still serious, the progress of the disease has been arrested.——Dr. Harry E. Welch, Youngstown, has been reelected health officer by a unanimous vote.——The board of health of Dayton will make its headquarters at the home of Dr. Herbert C. Haning, a member of that board, at 143 West Fourth Street.

Cleveland

School Notes.—Fourteen men were graduated at the sixty-seventh annual commencement of the medical department of the Western Reserve University. The following faculty changes have been announced: Dr. George W. Crile was made professor of surgery; Dr. Carl A. Hamann has resigned as professor of anatomy and has been elected professor of applied anatomy and clinical surgery; Dr. Henry Gerstenberger was made assistant professor of pediatrics; Dr. Frederick C. Herrick, associate in surgery; Dr. Walter H. Merriam, associate in medicine; Dr. William H. Weir, associate in gynecology; Dr. John J. Thomas, associate in obstetrics; Dr. Davidson Black, associate in histology and embryology; Dr. James D. Pilcher, associate in pharmacology and materia medica; and George B. Farnsworth, instructor in obstetrics.——The medical department of the Ohio Wesleyan University, now absorbed by Western Reserve, graduates twenty-two men this year.

Personal.—Dr. John M. Ingersoll has sailed for Europe and will study in Vienna during the summer.——Dr. Henry O. Feiss has resigned his position as orthopedist to Lakeside Hospital and has suspended practice, expecting to devote his time to experimental research.——Dr. Chauncey W. Wychoff has been appointed assistant director of the Central Dispensary and Milk Laboratory of the Babies' Dispensary and Hospital.——Dr. Alfred I. Ludlow has resigned as demonstrator of surgical pathology in Western Reserve Medical Department.——Dr. Rodger G. Perkins has departed for his summer home in Rhode Island.——Dr. Henry Gerstenberger, director of the Babies' Dispensary and Hospital, has entered private practice.——Dr. Arthur M. Tweedie has moved to Dickinson, N. D.——Dr. David Marine has gone to California for the summer, and will devote his time to research work. ——Dr. Harlan Pomeroy, who has been seriously ill with angina pectoris, is reported to be much improved.

PENNSYLVANIA

Births Exceed Deaths.—The bulletin of the State Department of Health, issued June 11, announces that in 1910 there were 209,636 births recorded in the state, as compared with 119,717 deaths.

Cement Region Physicians Meet.—The Cement Medical Association, at its annual meeting in Siegfried, June 6, elected the following officers: president, Dr. Edgar J. Klotz, Northampton; vice-president, Dr. Jacob E. Longacre, Weaversville; secretary, Dr. M. G. Miller, and treasurer, Dr. Nathan C. Peters, Cementon.

Personal.—Drs. Louis Starr, E. B. Mongel and Morris B. Miller have sailed for Europe.——Dr. J. Chalmers DaCosta received the honorary degree of LL.D. at the commencement exercises of the Villanova College, June 14.——Dr. Edgar Fahs Smith received the honorary degree of LL.D. from Rutgers College, June 21.

Philadelphia

Off for Europe.—Drs. Arthur V. Meigs, George Straworidge and Alfred R. Allen sailed for Europe, June 17.

Reduction in Infant Mortality.—According to the report of the Bureau of Municipal Research, 336 babies under 2 years of age died from January 1 to June 1 during the present year as compared with 418 for the corresponding period of last year, a decrease of 20 per cent.

University Commencement.—At the 155th annual commencement of the University of Pennsylvania, held in the Academy of Music, June 21, Thomas R. Marshall, Governor of Indiana, delivered the address to the graduates and 152 men received the degree of doctor of medicine.

Personal.—Dr. John A. Kolmer has been elected professor of pathology and director of laboratories in the Philadelphia Polyclinic and College for Graduates in Medicine.——Dr. James C. Wilson, professor of practice of medicine and clinical medicine at the Jefferson Medical College for twenty years, has resigned.

Pier Hospitals Opened.—The summer's campaign against infant mortality was begun June 15 with the opening of the Chestnut Street and the Race Street Piers for poor children. There is a hospital on each one, but the Race Street Pier will be open day and night and will confine its work to the sick children, while the Chestnut Street Pier will be an open air playground and the beds will be used for tired children and those too small to walk. Milk will be supplied free to mothers for their infants and modified milk and barley water will be sold for 1 cent a bottle. Six nurses have been allotted to this work, three to each pier, and Dr. L. A. Wilkes is in charge of the Race Street Pier.

TENNESSEE

Nashville and Tennessee Universities Dissolve Relations.—The medical departments of the University of Nashville and the University of Tennessee, Knoxville, combined more than a year ago for the purpose of greater efficiency, have dissolved relations. The medical department of the University of Tennessee will be removed to Knoxville; that of the University of Nashville will be abandoned.

WISCONSIN

Personal.—Dr. and Mrs. Martin Hagen, Cashton, sailed for Europe, May 30.——Dr. Wade Hampton Brown, Madison, formerly assistant professor of pathology in the University of Wisconsin, has been elected professor of pathology in the University of North Carolina, Chapel Hill.—Dr. Aaron Yaffe, Milwaukee, intern in the Emergency Hospital for two years, has resigned.——Dr. John M. Dodd, Ashland, fractured his right arm, June 1, while cranking his automobile.——Dr. Bartholomew Bantley, for eight years surgeon of the Wisconsin Veterans' Home, Waupaca, has returned to Milwaukee to resume practice.——Dr. John P. G. Bjorkman, Racine, who has been critically ill with septicemia for several months, has recovered and resumed practice.——Dr. Sherman E. Wright, Marinette, has been made an honorary member of the Fox River Valley Medical Association.——Dr. Calvin F. Hess, Madison, who was operated on, May 2, for appendicitis, is convalescent and has returned home.——Dr. L. Winfred Sayles has been appointed health officer of Baraboo.——Dr. Maurice A. Bernstein, Kenosha, has been appointed senior physician at the Cook County (Ill.) Infirmary, Oak Forest.

GENERAL NEWS

Tri-State Physicians Meet.—At the semi-annual meeting of the Tri-State Medical Association of Ohio, Indiana and Michigan, held in Toledo June 6, the following officers were elected: president, Dr. Charles M. Smith, Toledo; vice-president, Dr. Victor C. Vaughan, Ann Arbor, Mich.; secretary, Dr. George W. Spohn, Elkhart, Ind. (reelected), and treasurer, Dr. Joseph A. Weitz, Montpelier, O. (reelected). The next meeting will be held in Fort Wayne Ind., in December.

Pediatrists Elect.—At the twenty-third annual meeting of the American Pediatric Society, at Lake Mohonk, N. Y., May 31-June 2, the following officers were elected: president, Dr. Augustus Caille, New York City; vice-president, Dr. Percival J. Eaton, Pittsburg; secretary, Dr. Samuel S. Adams, Washington, D. C.; treasurer, Dr. Charles Hunter Dunn, Boston; recorder and editor, Dr. Linnaeus E. La Fetra, New York City. The next meeting will be held in Hot Springs, Va., May 29-31, 1912.

National Association for the Study of Epilepsy and the Care and Treatment of Epileptics.—At the tenth annual meeting of this association, held in St. Louis, June 16, the following officers were elected: president, Dr. William T. Shanahan, Sonyea, N. Y.; vice-presidents, Mr. W. C. Graves, Chicago, and Dr. Albert S. Priddy, Keyesville, Va.; secretary-treasurer, Dr. James F. Munson, Sonyea, N. Y.; chairman of the executive committee, Dr. David F. Weeks, Skillman, N. J.; and editor of transactions, Dr. William P. Spratling, Baltimore. The place of meeting for 1912 is yet to be decided.

Throat, Nose and Ear Specialists Hold Meeting.—The American Laryngological, Rhinological and Otological Society held its seventeenth annual meeting at Atlantic City, June 1-3, and the following officers were elected: president, Dr. G. Hudson-Makuen, Philadelphia; vice-presidents, Drs. Theodore W. Corwin, Newark, N. J., chairman of the eastern section; John A. Thompson, Cincinnati, chairman of the middle section; Dr. Thomas J. Gallaher, Denver, chairman of the western section, and Dr. Otto Joachim, New Orleans, chairman of the southern section; secretary, Dr. Thomas J. Harris, New York City, and treasurer, Dr. Ewing W. Day, Pittsburg, Pa.

Rockefeller Institute Staff Appointments.—At a recent meeting of the Board of Scientific Directors of the Rockefeller Institute for Medical Research the following staff appointments were made: Dr. Alfred E. Cohn, associate in medicine; Dr. Arthur W. M. Ellis and Alphonse R. Dochez, assistant resident physicians; Dr. Frank W. Bancroft, associate in experimental biology; Dr. Reinhard H. Beutner, assistant in experimental biology; Drs. James B. Murphy and Henry K. Marks, assistants in pathology; J. J. Bronfenbrenner, fellow in pathology; Dr. Frederick B. LaForge and Angelina M. Courtney, assistants in chemistry, and Helen L. Fales, research scholar in chemistry.

Climatologists Meet.—The annual meeting of the American Climatological Association was held in the new medical building of McGill University, Montreal, June 1 and 2, and the following officers were elected: president, Dr. A. D. Blackader, Montreal; vice-presidents, Drs. H. M. King, Loomis, N. Y., and Carroll E. Edson, Denver; secretary-treasurer, Dr. Guy Hinsdale, Hot Springs, Va.; representative on the executive committee, Dr. Roland G. Curtin, Philadelphia; alternate, Dr. Thomas Darlington, New York; councilors, Drs. John W. Brannan, New York, Thomas Darlington, New York, Thomas D. Coleman, Augusta, Ga., Charles E. Quimby, New York, and Edward R. Baldwin, Saranac Lake, N. Y.

Mississippi Valley Medical Meeting.—The preliminary announcement of the thirty-seventh annual meeting of the Mississippi Valley Medical Association has been issued. The association will meet at Nashville, Tenn., October 17-19, under the presidency of Dr. Robert H. Babcock, Chicago, the subject of whose address will be "Medical Tendencies." The address in surgery is to be delivered by Dr. Joseph D. Bryant, New York City, on "The Indebtedness of Posterity to the Pioneer Surgeons of the Mississippi Valley," and the address on medicine by Dr. James C. Wilson, Philadelphia, on "Doctors and the Public." There is to be a symposium, including both sections of the society, on the "ptoses," with papers by Drs. E. W. Suckling, Birmingham, Eng., on visceroptosis, and a report of four hundred operations for nephroptosis by Mr. D. Billington, Birmingham, Eng. There will also be symposiums on cholecystitis and genito-urinary diseases.

CANADA

Provincial Medical Association.—At the annual meeting of the Ontario Medical Association, held in Niagara Falls, May 30-June 1, the following officers were elected: president, Dr. Herbert A. Bruce, Toronto; vice-presidents, Drs. F. W. E. Wilson, Niagara Falls, William Hall, Brampton, F. Drake, London, and George Field, Coburg; general secretary, Dr. F. A. Clarkson, Toronto, and treasurer, Dr. J. Heurner Mullin, Hamilton.

National Laboratory at Ottawa.—Under the supervision of the Health Department of the Canadian Conservation Commission, Canada is to have established in the immediate future, a national laboratory for the manufacture of sera, vaccines, toxins and antitoxins. A subcommittee of the federal cabinet has approved of the proposal and has recommended speedy provision for the construction and equipment of the laboratory. This proposition also was endorsed by the Canadian Medical Association at several of its recent meetings.

Medical Convocation at McGill.—At the medical convocation of McGill University on the 5th of June, thirty-one candidates received their M.D., C.M. degrees. Dean Shepherd announced Lord Strathcona's latest gift of $100,000 for the completion of the new medical buildings. Honorary degrees of doctor of laws were conferred on Drs. Richard A. Reeve and Prof. Archibald B. MacCallum, Toronto; Dr. John Stewart, Halifax, and Hon. Dr. Henry E. Young, Victoria, B. C., and Drs. L. E. Barker and W. T. Councilman of the United States.

McGill Medical Reunion—New Medical Building Opened.—June 5 and 6 were the days set apart for the McGill medical reunion and the opening of the new medical buildings. The ceremony of opening the buildings was performed by Earl Grey, who was presented with a gold key for the occasion. The new medical building is by far the largest building of the group of buildings which comprise the university. It has a frontage of 268 feet toward the campus, and the east and west wings run back, respectively, 171 and 114 feet. The erection of this building was made possible by the generous donation of $450,000 by Lord Strathcona, which went to supplement handsomely the insurance of $336,500 on the buildings destroyed a few years ago by fire. The medical reunion brought together over 500 graduates.

Personal.—Dr. George A. Armstrong, Montreal, has been appointed chief surgeon at the Royal Victoria Hospital, Montreal, in succession to the late Dr. James Bell.——Dr. Andrew MacPhail, Montreal, was severely injured by the explosion of a bottle of aerated water, June 14.——Drs. J. W. Harris and George M. Biggs, London, have resigned from their positions on the staff of the London Hospital for the Insane and have sailed for England. The staff of the hospital presented them with a steamer trunk, club bag, gold-headed umbrella and addresses.

Annual Report, Queen's Medical Faculty.—The past session at the medical department of Queen's University, Kingston, Ont., was the largest in its history, the number in attendance being 232. Many other applications for admission were received but rejected for various reasons, showing that Queen's keeps a keen edge on the class of candidates it admits to the study of medicine. Twenty former students were also refused admission on account of incomplete matriculation. Owing to the death of Dr. Isaac Wood, Dr. Gordon W. Mylks was appointed associate professor of obstetrics and gynecology and professor of pediatrics; and Dr. Charles Alex Morrison appointed to succeed Dr. Mylks as associate professor of applied anatomy. Dr. George E. Kidd took charge of the anatomic department, succeeding Dr. Frederick Etherington, resigned. Dr. Kidd is, at present, spending the summer in Glasgow, London and Edinburgh. The faculty decided to develop its library and spend $5 per student per year on its maintenance.

Queen's University and the Ontario Medical Council.—In the bulletin issued quarterly by the Medical Faculty of Queen's University, Kingston, Dean Connell has something to say with regard to the proposed amendment to the Ontario Medical Act, fathered by the University of Toronto to confer special privileges, as regards examinations and licenses, on that institution. The proposed amendment did not find favor with the legislature nor yet with the medical profession at large throughout the province. The article states that "The council stands for a principle which is of vital interest for the maintenance and advancement of medical education in the province." Dean Connell considers that the council must grant a radical measure of reform or cease to exist—and this reform must take place at the coming meeting of the council in July. Propositions are advanced which will be supported by the representative from Queen's and also, it is understood, by other members of the council. 1. Matriculation to be uniform with junior matriculation in arts as conducted by the education department. 2. The universities to arrange the details of the courses; five years. 3. One final examination at the end of the fifth year; a workable system of assessors. 4. Fees reduced materially, say from $25 to $50; probably the establishment of fellowships or research scholarships. 5. Reorganization of the council as follows: eight territorial representatives, one homeopath, and three collegiates; thus doing away with four homeopaths, ten territorials and the five representatives from defunct medical institutions.

PARIS LETTER

(From Our Regular Correspondent)

PARIS, June 16, 1911.

An Attempt to Assassinate Dr. Guinard

June 12, when Dr. Guinard, surgeon of the Hôtel-Dieu, was leaving the hospital, one of his former patients, named Herrero, sprang from behind a pillar and fired five shots into the surgeon's back before anyone could interpose. The would-be assassin said that he wished revenge on Dr. Guinard for excising his rectum without cause. Dr. Guinard was taken to the operating room, where Drs. Rochard and Pierre Duval performed a laparotomy, finding six intestinal perforations.

May a Pharmacist Absent Himself Regularly from His Shop?

The tribunal of the Seine was recently called on to decide the question whether or not a pharmacist who is regularly absent from his shop, except from 5 to 7 p. m., is thereby breaking the law. The pharmacist's apprentice and the pharmacist himself were both prosecuted: the first for illegal practice of pharmacy, and the second for complicity therein. The line of defense was that prescriptions were filled only in the

evening under the eyes of the pharmacist. During the day the apprentice sold only non-medicinal products such as mineral waters, tooth pastes, etc. Under these conditions the defense held there was no illegal practice of pharmacy, even in the pharmacist's absence. The court, however, ruled against the defense and imposed on the apprentice a suspended fine of $100 (500 francs). It fined the pharmacist the same amount but did not suspend his fine. The Syndicat des pharmaciens, which was civil party to the suit, moreover obtained $40 (200 francs) as damages.

The Heroic Death of a French Army Physician

A dispatch from Ras-el-Ma announces that Dr. Lucien Auvert has just died like a hero in Morocco in the engagement of Mékès, two hours' distant from Fez. At the time of the first expedition to Morocco Dr. Auvert asked to be allowed to accompany the column but his request was refused. It was granted, however, at the beginning of the second campaign. Major Auvert had distinguished himself everywhere by acts of bravery, and his death, on the firing-line, where he was caring for a wounded soldier, was a fitting close for such a life. The injured soldier was about to be removed from the firing-line to have his wound dressed. "No," said Auvert, "to carry him away would be fatal. In a few minutes I can make a first dressing which may save him." While endeavoring to save the man's life he himself fell mortally wounded.

A Duty of Specialists Toward General Practitioners

In medical circles the question of the duty of specialists toward general practitioners is being warmly discussed in connection with the following incident: A Belgian physician attended a young married woman during her pregnancy and confinement, which presented nothing abnormal. The child was healthy. Nine months afterward the physician attended the same patient for a uterine affection. The husband then confessed to the physician that he had infected his wife at the time of his marriage and that she had been treated by a specialist who had had her under intensive mercurial treatment from the beginning of the pregnancy, but had failed to warn the obstetrician who had charge of the confinement. Thus the obstetrician and the nurse ran the risk of infection, for, being unwarned, they had taken no unusual precautions. There can be no doubt that a specialist does not infringe on medical secrecy in confiding to another physician, likewise bound to secrecy, the nature of a patient's disease, and that the specialist in the present case neglected a manifest duty in omitting to warn his colleague.

The Franco-American Institute

In a previous letter (THE JOURNAL, Feb. 12, 1910, p. 549) I mentioned the formation of the "Franco-America" committee for promoting exchanges between the United States and France. Frenchmen and Americans belonging to the scientific, artistic and political world, met on June 14 in the ministry of public instruction and formed the Franco-American Institute for the purpose of facilitating such exchanges. M. Emile Boutroux, who has recently visited the principal university and literary centers of the United States, made an interesting communication in which he sketched the intellectual and moral evolution which is taking place among the Americans, who are now, he said, learning to respect the antiquity which they have long despised in favor of bizarre novelties.

Medical Students and Classical Studies

During its last session the committee of the Association corporative des étudiants en médecine de Paris unanimously passed a resolution to the effect that classical studies constitute a preparation for medical study altogether superior to that which most young people intending to study medicine receive, and that in future no substitution ought to be allowed for the present diplomas and the baccalaureate degree, which are the best means of controlling secondary studies.

BERLIN LETTER

(From Our Regular Correspondent)

BERLIN, June 10, 1911.

Personal

Professor Payr of Königsberg has been called to Leipsic as the successor of Professor Trendelenburg. Payr came to Königsberg a short time ago from Greifswald.

Professor Dürck, director of the institute of pathologic anatomy at Jena, is exchanging places with the prosector of the municipal hospital on the right of the Isar in Munich. This remarkable occurrence, in which a regular professor abandons his position for that of a prosector, is explained by the fact that in the first place Dürck is a native of Munich, and probably does not feel at home in Jena, a small university town, and further by the continual lack of pathologic material in Jena. Dürck was for many years assistant at the pathologic institute in Munich.

At the close of the summer semester, Prof. B. Fraenkel will resign his position on account of his advanced age and his impaired health of late years. The oft-renewed question whether the Berlin laryngologic clinic shall be maintained as a separate department or be merged with the otologic clinic will now attract attention. In general, the wish is expressed here that the former policy may be pursued and that Professor Killian of Freiburg may be asked to take Fraenkel's place. The contrary tendency, to unite both clinics under the direction of the otologist, Professor Passow, is so strong on account of the influence which Passow possesses in court circles, that it is doubtful how the question will be decided.

Professor Ehrlich has been elected as an honorary member of the Academy of Sciences at Bucharest, and has received the Liebig medal of the German Chemical Society as a special honor. The honors accorded to the discoverer of salvarsan are accumulating in an uncanny way and to an extent quite out of proportion to the real value of his discovery, and to the honors which such men as Robert Koch, Pasteur, Behring and other discoverers in former times received. The value of such distinctions in general, especially in Germany, has depreciated remarkably in consequence of their commonness of late. A striking example of this fact is the circumstance that the city of Kolberg voted the freedom of the city to a member of the Prussian state medical department, Professor Dietrich, for his services in organizing the recent congress of thalassotherapy. To obtain such an honor, the highest which a city can bestow, a man should have performed greater services than merely to make arrangements for holding a scientific annual meeting.

The Königsberg anatomist, Stieda, celebrated the semicentennial of his doctorate June 10.

Legal Consequences of a Physician's Experiment

As a result of his studies on trachoma which led him to the apparent result, not confirmed by others, that the germ of trachoma was a modified gonococcus, Dr. Herzog, privat-docent in ophthalmology in Berlin, undertook experiments in April of last year in the ophthalmologic clinic at the municipal hospital of Triest, to confirm his conclusions. Among other methods he asked of Dr. Manzutto, the director of the department, the privilege of inoculating the blind eye of a patient with a culture of gonococci. Dr. Manzutto at first refused his consent on account of the danger of causing an infection of the sound eye, but he finally allowed himself to be persuaded to consent. Without the knowledge of Dr. Manzutto, Dr. Herzog made a second injection, and that after the sound eye had been operated on for cataract. Soon after the injection of a virulent gonococcus culture, an inflammation of the operated eye set in which endangered vision, but was finally cured. As a result of the injury to the patient suit was entered against Dr. Manzutto, while Dr. Herzog, anticipating that he would be held responsible, left Austria. Dr. Manzutto was fined $50 by the lower court, but he appealed from this judgment and was acquitted at the second trial, on the plea that he could not have supposed that a man of recognized scientific reputation would, behind his back, apply a method different from that which had been discussed between them.

Care of the Insane in War

A number of measures for the care of the insane in time of war have been taken by the Prussian military authorities. A supply of hypnotics and sedatives for quieting excited maniacs has been installed at the individual army posts. As under some circumstances it may be necessary to provide a special ward for the insane, there have been provided for each depot of supplies twelve tubs for permanent baths, twenty box or lattice beds, twenty pairs of shoes which cannot be torn, twenty straight jackets, and finally a number of earth-closets (*Torfmullklosetts*). A number of the nurses of the military hospital service have been specially trained for the care of the insane. An increasing number of physicians are required to attend psychiatric clinics in receiving their training so that a sufficient number of the medical force will be available for the care of mental cases. Special cars for the transport of these patients to their homes need not be provided, as the ordinary hospital train can be adapted to this purpose, with a few slight changes which can be quickly made and will not be needed in the first few weeks of a war.

Urine Examination in Official Public Health Work

The faculty of the Kaiser Wilhelm military medical school has reported on the question whether a reliable reagent for the detection of albumin in urine can be recommended for the examination case of sanitary officers. The report states that albumin and globulin occur in traces in normal urine, but that these traces are not discoverable by the classic tests without especial preparation. A urine in which these tests give negative results may be regarded as free from albumin. On the other hand, all albuminurias of clinical importance are detected by the ordinary tests. As army surgeons cannot carry caustic liquids in their outfit, the materials for the test of Bödeker in the form of powdered citric acid and tablets of potassium ferrocyanid are to be recommended. Naphthalinsulphonic acid, on which the faculty was asked to make a special report, may be regarded as a serviceable test for albumin, but must be used by a physician acquainted with the sources of error.

Hygiene and Votes for Women

With us the advocates of woman's right to vote on social and political questions use every opportunity to advance their cause. Thus there is to be a discussion at a conference held by the advanced women's clubs of Dresden, in connection with the international exposition of hygiene, on the connection between hygiene and woman's suffrage. The care of youth, housing reform, protection of working women, prostitution, and the campaign against alcohol are to be discussed in a series of addresses from the standpoint of woman's suffrage. A public meeting in behalf of the cause is to be held in the large lecture hall of the hygiene exposition, at which addresses will be made on the importance of woman's suffrage in its relation to the family, the community and the state.

Marriages

CLARENCE LEONARD OLSON, M.D., McIntosh, S. D., to Miss Ruth Eleanor Cook of Mankato, Minn., June 14.

JAMES HENRY HATFIELD, M.D., Barren Fork, Ky., to Miss Julia McClancy of Flat Rock, Ky., June 12.

THOMAS LINWOOD BENNETT, M.D., New York City, to Miss Ethel Hope of Bayside, L. I., June 10.

ALBERT MERHER MOORE, M.D., to Miss Annie Haseman Brown, both of Philadelphia, June 6.

CHARLIE A. FOWLER, M.D., Supply, Okla., to Miss Grace A. Cunningham, at Bevier, Mo., May 30.

WALTER TRUSLOW, M.D., to Miss Josephine Stearns Bacchus, both of Brooklyn, N. Y., June 14.

ETHAN A. NEVIN, M.D., Newark, N. Y., to Miss Louise Hart Dolley of Albion, N. Y., June 10.

FRANK J. POKORNEY, M.D., to Miss Charlotte Henrietta Wolf, both of Chicago, June 13.

JACOB ROSENBLOOM, M.D., New York City, to Miss Merla G. Cohen of Baltimore, June 14.

WILLARD THOMPSON, M.D., Chicago, to Miss Hazel Crofoot of Sandwich, Ill., June 14.

LEO THOMAS MYLES, M.D., to Miss Helena Murphy, both of Cambridge, Mass., June 13.

DEMETER KALINOFF, M.D., to Miss Alice Pennington, both of Stillwater, Minn., June 8.

WALTER ESTELL LEE, M.D., to Miss Margaret Gordon, both of Philadelphia, June 14.

ARTHUR D. BECHTEL, M.D., to Miss Leita Jones, both of Sacramento, Cal., June 3.

HERMAN J. BETTEN, M.D., to Miss Edith B. Dawes, both of Garneill, Mont., June 8.

JOHN BODINE LOWMAN, M.D., to Miss Ray Test, both of Johnston, Pa., June 14.

HENRY P. GRAUL, M.D., St. Louis, to Miss Alice Hafner of Haven, Kan., June 14.

ROSS C. OTTINGER, M.D., to Miss Edith Lawrie, both of Indianapolis, June 14.

JANET MALCOLM, M.D., to John F. Wohlgemuth, both of Chicago, June 10.

PAUL RIDER, M.D., to Miss Nellie Delia Morris, Morgantown, W. Va., June 13

Deaths

Daniel M. Dill, M.D. University of Michigan, Ann Arbor, 1867; of Newark, N. J.; a veteran of the Civil War; at one time coroner of Essex County; a member of the Board of Freeholders from 1884 to 1890 and again from 1892 until 1900; formerly superintendent of the Essex County Hospital for the Insane; a member of the Medical Society of New Jersey; at one time on the visiting staff at St. Barnabas Hospital, Newark; died at his home, June 9, from nerve paralysis brought on by injuries received in a fall several years ago, aged 71.

Benjamin B. Leonard, M.D. Medical College of Ohio, Cincinnati, 1853; a veteran of the Civil War; ex-president of the Ohio State Medical Association, the Northwestern Ohio and the Logan County Medical Societies; an honorary member of the Indiana and West Virginia State Medical Associations, and the Alumni Association of Jefferson Medical College; died at his home in West Liberty, O., June 15, from chronic gastritis, aged 86.

James Carmichael Hutchison, M.D. College of Physicians and Surgeons, New York City, 1866; a member of the American Medical Association; formerly president of the Rensselaer County (N. Y.) Medical Society; for twenty-three years attending physician to the Troy Hospital; died at the home of his daughter in Rockford, Ill., June 11, from cerebral hemorrhage, aged 65.

William Harvey Rush, M.D. Washington University, St. Louis, 1901; a member of the American Medical Association; lecturer on clinical chemistry and microscopy in his alma mater; a member of the staff of Washington University Hospital and clinical assistant in Washington University Hospital dispensary; died suddenly at his home in St. Louis, June 2, aged 45.

William J. Mathews, M.D. University of Tennessee, Nashville, 1890; a practitioner of Austin, Tex., for over thirty-five years; formerly a member of the American Medical Association; attending physician at St. Edward's and St. Mary's Colleges; at one time city health officer; formerly president of the school board; died at his home, June 6, aged 62.

John Lewis Fortier, M.D. Medical School of Maine, Brunswick, 1883; a member of the Maine Medical Association and Waterville Clinical Society; an alderman of Waterville from 1908 to 1910; for many years city physician, and in 1908 representative in the state legislature; died at his home, June 4, aged 58.

John Henry Brierley, M.D. Starling Medical College, Columbus, O., 1878; of Glasco, Kan.; formerly a member of the American Medical Association; a member of the state legislature for several terms; local surgeon of the Union Pacific Railroad; died at a hospital in Kansas City, June 14, aged 62.

Jacob C. Kreamer, M.D. Berkshire Medical College, Pittsfield, Mass., 1859; of Aquashicola, Pa.; a member of the Carbon County Medical Society; formerly coroner of Carbon County; at one time a member of the state legislature; died at his home, June 7, from paralysis, aged 77.

Harvey A. Warner, M.D. University of Wooster, Cleveland, O., 1873; of Topeka, Kan.; a member of the Kansas Medical Society; lecturer on life insurance in the Kansas Medical College, Independence; died at his home, June 9, from a stroke of apoplexy received February 16, aged 61.

Charles F. Doyle, M.D. Jefferson Medical College, 1880; of Centreville, Pa.; a member of the Bedford County Medical Society; coroner of Bedford County; tax collector and school director of his township; died at his home, June 6, of locomotor ataxia, aged 55.

William H. Riker, M.D. Medical College of Ohio, Cincinnati, 1876; a member of the American Medical Association; president of the Darke County Medical Society; died at his home in Versailles, O., May 27, from cancer of the bowels, aged 61.

David S. Livingston (registration, Texas, 1902); of Llano; formerly a member of the American Medical Association; division surgeon of the Atlanta & Pacific Railroad; died in a hospital in Austin, June 5, from appendicitis, aged 50.

James Taylor Williams, M.D. Medical College of Virginia, 1881; for many years a practitioner of Russell County, Va., and Sullivan County, Tenn.; died at his home in Bristol, Tenn., April 24, from asthma, aged 59.

Irving W. Johnson, M.D. Homeopathic Medical College of Pennsylvania, Philadelphia, 1856; one of the oldest practitioners of Illinois, died at his home in Peoria, June 12, of septicemia, due to a carbuncle, aged 79.

Frederick Adam Powell, M.D. Jefferson Medical College, 1891; a member of the American Medical Association; oculist and aurist of Sioux City, Ia.; died at his home, June 7, from disease of the liver, aged 43.

Charles Ellis Holmes, M.D. Medical College of Georgia, Augusta, 1901; of Millen, Ga.; member of the city council; county, city and railroad physician; died at his home, June 12, from acute indigestion.

John Wesley Watenpaugh, M.D. Hahnemann Medical College of the Pacific, San Francisco, 1905; of Weaverville, Cal.; died in a Redding, Cal., hospital, May 25, from typhoid fever, aged 32.

Humphrey Howell Bate, M.D. Medical Department University of Nashville (Tenn.), 1868; a veteran of the Civil War; died at his home near Castalian Springs, Tenn., June 8, aged 66.

Daniel Joseph Kelley, M.D. Jefferson Medical College, 1902; a member of the American Medical Association; died at his home in Worcester, Mass., June 10, from kidney trouble, aged 53.

Solomon S. Stearns, M.D. Georgetown University, Washington, D. C., 1868; a veteran of the Civil War; died at his home in Washington, D. C., June 10, from heart disease, aged 72.

Ransom Terry, M.D. University of Buffalo (N. Y.), 1874; one of the best known practitioners of Cattaraugus County, N. Y.; died at his home in Hinsdale, June 8, aged 72.

Clarence E. McFall, M.D. Louisville (Ky.) Medical College, 1891; formerly of Peoria, Ill.; was killed, June 6, by a cave-in while digging a trench on his ranch at Corona, Cal.

Charles Ott, M.D. Ensworth Medical College, St. Joseph, Mo., 1895; of Kansas City, Kan.; died at the home of his son in Higginsville, Mo., June 9, from nephritis, aged 60.

Thomas Hartford Wileman, surgeon of volunteers during the Civil War; died at his home in Seneca, Kan., January 3, from senile debility, aged 81.

Aaron B. Avery, M.D. University of Michigan Homeopathic College, Ann Arbor, 1878; died at his home in Pontiac, Mich., June 12, from heart disease.

Eugene S. Judkins, M.D. Miami Medical College, Cincinnati, 1870; of Highland, O.; died at Evanston, O., June 13, from Bright's disease, aged 65.

John A. Farren, M.D. Baltimore (Md.) Medical College, 1893; of Chicago; was found dead in Hot Springs, Ark., June 1.

John William Reno (license, Kansas, 1901); died at his home in Tonganoxie, June 3, from heart disease, aged 65.

George W. Walden (license, Missouri, 1883); of Miami Station, Mo.; died at his home, June 5, aged 81.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER MATTER TENDING TO AID INTELLIGENT PRESCRIBING AND TO OPPOSE MEDICAL FRAUD ON THE PUBLIC AND ON THE PROFESSION

DEKOFA

A Caffein-Poor Coffee

To those who would indulge their cravings, but whose health will not permit such indulgence, alcohol-free beer, nicotin-free cigars and caffein-free coffee is an ever-alluring subject. Unfortunately these articles have in the past been free from their objectionable constituents in name only, or if true to claim were unsatisfactory substitutes for the real articles—for beer without alcohol, tobacco without nicotin and coffee without caffein is much like "Hamlet" with Hamlet left out. In the end, those whose health interdicts the use of these stimulants wisely become total abstainers rather than consumers of unsatisfying substitutes, which but perpetuate the craving.

Recently a "decaffeinated" coffee, advertised and sold in this country by Merck & Co., first as "Dekafa" and now as "Dekofa," has attracted some attention, judging from the inquiries received regarding it. It is evident from these inquiries that physicians in view of past experiences no longer rely on the unconfirmed statements of manufacturers but require more convincing evidence than such statements before accepting the product for what it is sold. In view of the many inquiries regarding Dekofa the Association chemists investigated the product and report:

Dekofa is sold on the retail market in 1-pound packages labeled:

"Dekofa—a genuine coffee from which the stimulating drug caffein has been largely removed. Particularly adapted for those to whom ordinary coffee is forbidden."

"Use precisely as ordinary coffee—no special directions for making are needed."

Besides the above the following statements, some addressed to the laity and others to the profession are found in the advertising matter:

"Does the doctor forbid you coffee? Then ask him about Dekofa or Merck's 'Caffeinless' coffee. Most probably he'll let you drink that—and lots of it too."

"Drink it at home and you won't have to drink it in Europe—and you may not have to go to Europe for your health, either."

"There is no need of you forbidding coffee to your patients troubled with 'heart' or 'nerve' or 'stomach' complaints, if you will direct them to use Dekofa, Merck's 'Caffeinless Coffee.'"

"The average caffein content of ordinary coffee is 1.3 per cent. Dekofa contains appróximately 0.13 to 0.15 per cent. of caffein or about 10 per cent. only of the normal content."

From the standpoint of the chemist the claims made by the manufacturer bring up for discussion the following points: Dekofa is spoken of as "Merck's Caffeinless Coffee." This term would signify that the coffee is free from caffein but as the firm makes a statement that the product contains 0.13 to 0.15 per cent. caffein it is evident that here the manufacturers seek exemption from the truth under a sort of poetic license enjoyed in the past by "patent medicine" exploiters. The use of the phrase "caffeinless" can do but one thing—disguise the truth and hence should be dropped.

The firm asserts that "the average caffein content of ordinary coffee is 1.3 per cent." According to published analyses the caffein content of coffee varies from 0.64 per cent.[1] to 3.64 per cent.[2] This variation is due in part to natural causes and in part to the unsatisfactory methods of assay. Thus one investigator finds in coffee of different sources 0.64 to 1.53 per cent. caffein,[3] while three experimenters, working on the same specimen of coffee, reported, by the provisional method of the Official Agricultural Chemists, results ranging from 0.28 per cent. to 0.89 per cent. caffein and by another method from 1.02 per cent. to 1.21 per cent. caffein.

These results make it evident that no reliable average caffein content for coffee can be given, particularly when the method of assay is not defined. We are not in a position, however, to deny the correctness of the average caffein content of coffee as given by Merck & Co., nor, therefore, the claim that the presence of 0.13 per cent. caffein is an indication that 90 per cent. has been extracted. Assuming for the present that 0.13 per cent. caffein does indicate the removal of 90 per cent., and in view of repeated inquiries it was decided to determine whether the actual caffein content of this product on the market agrees with the manufacturers claims.

To determine the caffein content (1) the modified provisional method of the Association of Agricultural Chemists (*loc. cit.*) and (2) a method proposed by Görter (*ibid.*) were used and the following results obtained:[4]

1. (*a*) 0.13 per cent.; (*b*) 0.17 per cent. or an average of 0.15 per cent. caffein.

2. (*a*) 0.21 per cent.; (*b*) 0.25 per cent. or an average of 0.23 per cent. caffein.

Although these results vary somewhat, due to the different methods of assay used, they show that the caffein content of the product agrees in general with the claims. In conclusion it may be said that in those cases in which physicians feel called on to interdict the use of coffee and in which the patient is not willing to give up the habit, this product—unsatisfying as it is—may be used with the knowledge that it is relatively free from caffein.

1. Arch. Pharm., 1876, p. 294.
2. Allg. Kaffee Zeitung, Rotterdam, from Proc. Amer. Pharm. Assn., 1885, p. 144.
3. Arch. Pharm., 1876, p. 294.
4. The details of analysis will appear in the annual report of the Association laboratory.

Correspondence

Salvarsan and Patents

To the Editor:—I was very much interested in the article by Dr. F. E. Stewart of Germantown, Pa., that appears on page 1676 of your journal of June 3, 1911. [It is not the article, but an abstract thereof, in the report of a society meeting.—ED.]

I have noticed a number of articles of this kind on Salvarsan and Professor Ehrlich, appearing in many instances in the "house journals," or written by indirect employees of some of the manufacturing concerns on this side. [Our correspondent here refers to the connection of Dr. Stewart with the H. K. Mulford Co.—ED.]

It is interesting to note that Dr. Stewart says, "we are told." It is hard to tell by whom "we are told," and a statement a little more definite would be interesting. Without going into the merits of Professor Ehrlich's discovery, or the Professor's professional ethics, which I hardly believe need any championing, did it ever occur to the physicians at large, what might happen if a product like Salvarsan which has taken years of research and large sums of money to perfect, were not patented or covered in some way to guarantee that the product finally put on the market, would be reliable?

I recall very clearly some years ago that when the Hoechst-Farbwerke, who are now putting out Salvarsan, also put diphtheria antitoxin on the market, they did not take the precaution of patenting it at the time, or copyrighting a name for the product. The result was that through the description of the works, which Consul-General Mason, then in Frankfurt, sent to the United States, it was only a short time before antitoxin plants sprang up all over this country. Not only private individuals, but local boards of health began to make antitoxin, without yielding the inventor or the firm that made it possible, through investigations, to produce the product commercially, any royalty or remuneration of any kind, but instead, depriving them of a legitimate market in which there was a great demand for the product.

The imported article paid 25 per cent. duty. When the McKinley tariff was under discussion, there appeared one morning a clause placing antitoxin in the dutiable list at 100 per cent. This was not inspired by any clamor for the "home product," but simply by some manufacturers on this side who had taken up the making of antitoxin. Senator White of California moved to have the clause stricken out, and it remained with a duty of 25 per cent., which it still pays.

A patent was eventually granted for antitoxin to the Farbwerke, but they never saw fit to avail themselves of this protection or interfere in any way with those manufacturing on this side.

Your files will probably show that in one city at least, which took up the manufacture of antitoxin, the unfortunates who were treated with it, died of lockjaw, although they were cured of diphtheria. Another one of the American manufacturers who very strenuously objected to the Board of Health of New York city selling antitoxin to other cities, I found on investigation, during my recent incumbency of the office of comptroller of this city, was one of the best customers that the board of health had for its surplus antitoxin, and that the firm in question bought it in bulk, put it out under its own label, and continued discussing the ethics and propriety of a municipality competing with a private industry.

If Professor Ehrlich and the Farbwerke, in the interests of all concerned, and primarily those needing the remedy, have decided to protect in every way its production by patent as well as trade mark in all countries of the world, they are certainly guaranteeing to the profession and the sufferers the quality of the product they use.

Undoubtedly, there are others who could manufacture Salvarsan, but it does not follow that every one with a laboratory, or stable for producing vaccine virus or antitoxin, can produce as complicated a chemical preparation as Salvarsan. It would be pretty hard to tell just what might be turned out if some one took up the manufacture on a large scale, and sold it in bulk for proprietary houses to sell under their own label.

It is not always well to generalize, and what may not be quite ethical in one case may be more than ethical, and in fact, eminently proper and fitting in another.

It is well sometime to inquire into the sources of these complaints, and the antecedents, and motives of some of those who either directly or indirectly are responsible for these veiled insinuations against the acts of others.

As before stated, neither Professor Ehrlich, nor Salvarsan, nor the Farbwerke Hoechst, need any apologies or justification for their acts from me. They are all large enough to stand by themselves on their records.

But to one who knows something about the inside of these matters, it is certainly illuminating and impressive to see the many ways in which some folks try to create unfavorable impressions regarding a new product, "of course," in the most "disinterested" manner, and on the basis of the "highest possible ethics."

H. A. METZ, New York.
President, Victor Koechl & Co.

[COMMENT.—This letter presents the views of a manufacturer of proprietary medicines. While there is some justification for his attitude, and while we do not wish at this time to discuss the ethics of proprietorship in medicines, we believe that the medical profession will disagree with the view taken. The public could have been protected in other ways than by monopolizing salvarsan. If Professor Ehrlich had published in detail the method of manufacturing salvarsan and had provided standards and tests whereby its good quality could be determined, the difficulty in securing for the medical profession a supply of unquestioned purity would not have been an insurmountable one.—ED.]

Commissions Offered and Refused

THE OFFER

Dr. ——— ———

Dear Sir:—You will receive our check for $3.00 for every woman for whom you prescribe one of our ——— ——— as soon as we receive our pay for it. Your patient will get the best materials and workmanship she ever had. . . .

Respectfully yours,

——— ——— Co.

THE ANSWER

——— ——— *Company,*

Dear Sirs:—I have your letter stating that you will send me a check for $3.00 for every woman for whom I prescribe one of your ———.

You are perhaps not aware that all right-thinking members of our profession make a note of such a letter, and take particular pains to see that no people are sent to you. We have a list of several manufacturers who offer us commissions or profit in one way or another, and we keep the list in order to make sure that no one is sent from us to them.

Yours truly,

——— ——— ———.

Single Trauma and Cancer.—H. Schöppler adds another to the few cases of this kind on record. A cancer developed in the breast of a woman of 36, a month after a fall on the stairs, the left breast striking the banister post. By the third month an excised scrap of the tumor showed carcinoma, and recurring growths developed two months after its removal. The breast had been previously normal, he states, and the single trauma had undoubtedly led to the development of a carcinoma. The case is reported in the *Zeitschrift für Krebsforschung*, 1911, x, 219. Abramowski in the same number publishes a study of the predisposition and irritation as factors in cancer. He ascribes the increasing prevalence of cancer in women to the measures to prevent pregnancy and the lack of breast nursing which affects injuriously both the mother and child. In men the consumption of alcohol is a predisposing factor.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

ROENTGEN-RAY PICTURE: ROENTOGRAM; ROENTGRAM

To the Editor:—What shall we call the Roentgen-ray picture? Every term proposed and used to date is too general or else too much of a jaw-breaker or time-waster. "Skiagram" is not a good term, for this means merely a shadow picture, whereas radium, the Becquerel rays and probably other substances soon to be discovered all produce shadow pictures. "Radiogram" is open to the same objection, since a number of different kinds of rays are able to produce shadow pictures. Life is too short and time too fleeting to use the term "roentgenogram," which roentgenologists are trying to force on the world. Even if we adopt it now it will be thrown out as useless ballast sooner or later. What is the matter with "roentogram?" This indicates the special Roentgen technic, while it is comparatively terse and is readily found in the index on turning to Roentgen. It seems absurd to index under A ("actinogram") or S ("skingram"), or X ("*x*-ray picture") what one naturally would turn to under R ("roentogram"). C.

ANSWER.—If long words trouble our correspondent, why not go one step further and use "roentgram"?

MALARIA AND METHYLENE-BLUE

To the Editor:—What is the dosage and method of administration of methylene-blue in chronic malaria? When was malaria discussed in your therapeutic column? G. P.

ANSWER.—Methylene-blue may be administered in doses of 0.13 gm. to 0.2 gm (2 to 3 grains), given in capsules with a little powdered nutmeg, repeated every four hours. The patient should always be warned that his urine will be colored blue. This treatment should never be used in estivo-autumnal malaria. The treatment of the different forms of malaria is discussed in the Department of Therapeutics in THE JOURNAL, Aug. 3, 1907, p. 427; Aug. 17, 1907, p. 615, and Aug. 31, 1907, p. 786.

PREPARATION OF COW'S MILK FOR MARKET

To the Editor:—Some years ago I read an article on preparing cow's milk for market. When fully prepared, according to this article, there was nothing added to the milk except 0.5 per cent. of water. Can you help me get that article?

H. S. PICKARD, North Syracuse, N. Y.

ANSWER.—Budde, in 1904, advocated the treatment of milk with 0.5 per cent. hydrogen dioxid and subsequent heating to 52 C. (125 F.) in a covered vessel and keeping at this temperature for eight or ten hours. Subsequent investigations appear to have shown that the process is unreliable, in that it does not completely destroy the bacteria and appears to destroy a ferment contained in milk, which is probably useful. The method is quite fully described in Hewlett's article "Experimental Investigation of the Budde Process for the Preservation of Milk" (*Lancet*, London, Jan. 27, 1906; abstr. in THE JOURNAL, Feb. 24, 1906, p. 621). The following references may be consulted:

Budde: New Method of Sterilizing Milk, *Hygiea*, lxvii, No. 3, 1904; abstr. in THE JOURNAL, May 21, 1904, p. 1396.
Medin, O.: Treatment of Milk with Peroxid of Hydrogen, *Hygiea*, March, 1908; abstr. in THE JOURNAL, May 23, 1908, p. 1762.

AN ERROR IN DOSAGE OF POTASSIUM IODID

To the Editor:—In the article by C. H. Snover on "Chronic Lead Poisoning" (THE JOURNAL, June 17, pp. 1799-1800), under the heading "Treatment" the author is made to give 30 gm. of potassium iodid three times daily. Should not this be 30 gr. three times a day instead of 450 gr.?

THOMAS H. DICKSON, JR., M.D., St. Paul, Minn.

ANSWER.—The dose as it appears on the printed page is certainly excessive. This is a case of a dropped decimal point. The dose in the manuscript read ".30 gm."

The Public Service

Medical Department, U. S. Army

Changes for the week ended June 24, 1911.

Frick, Euclid B., lieut.-col.; Ashburn, Percy M., major, and Thornburgh, R. M., major, ordered to proceed to Los Angeles to represent the Medical Department of the Army at the sixty-second session of the American Medical Association, June 27-30, 1911.

Fauntleroy, P. C., major, relieved from medical supply depot, St. Louis, and ordered to Fort Benjamin Harrison, Ind., for duty.

Manly, C. J., major, granted leave of absence for one month.

Dade, Waller H., M.R.C., will proceed from San Francisco to his home and on arrival report by telegraph to the adjutant-general of the Army; Lieutenant Dade will stand relieved from active duty in the M.R.C. on expiration of leave of absence granted him this date; granted leave of absence for three months and one day, to take effect on arrival at his home.

Hess, John H., D.S., granted leave of absence for one month, to take effect about July 5, 1911.

Stephenson, William, lieut.-col., in addition to his duties as assistant to the chief surgeon, the eastern division, assigned to him in general order 74, June 6, 1911, W.D., is detailed as sanitary inspector.

Austin, Thomas C., lieut., granted thirty days' leave of absence about July 1, 1911.

Chamberlain, W. P., major, relieved from duty in the Philippines division, Jan. 15, 1912, and directed to proceed to London, England, to attend course at the London School of Tropical Medicine, and on completion of this duty to proceed to New York City for further orders.

Stallman, George E., D.S., left Fort Sam Houston, Texas, on three months' leave of absence.

Snyder, H. McC., lieut., left Fort Leavenworth, Kan., with Company E, Fifth Artillery, to Camp Sparta, Wis.

Munson, Edward L., major, is ordered to proceed to Niantic, Conn., for duty as inspector-instructor of the sanitary troops of the State of Connecticut during encampment, July 17 to 22, 1911.

Winter, Francis A., major, granted thirty days' leave of absence.

Nichols, Henry J., captain, granted thirty days' leave of absence.

Kelly, John P., M.R.C., is relieved from duty at Fort Hamilton, N. Y., on the return of Major Hess, M.C., to that post, and will proceed to College Park, Md., and report to the commanding officer of the signal corps detachment at that place for duty.

Rukke, Guy V., captain, left Jefferson Barracks, Mo., on ten days' leave of absence.

Betts, Charles A., M.R.C., granted three months' leave of absence, with permission to go beyond the seas, to take effect about Sept. 15, 1911.

Stone, John H., major, retired from active service on account of disability.

Cooper, Wibb E., lieut., ordered to return to Fort D. A. Russell, Wyo.; granted thirty days' leave of absence about July 1, 1911.

Gray, William W., colonel, ordered to St. Paul, Minn., for temporary duty, and on completion thereof will proceed to San Francisco, as heretofore ordered.

Medical Corps, U. S. Navy

Changes during the week ended June 24, 1911.

Cohn, I. F., P. A. surgeon, detached from the *Castine* and ordered to the *Michigan*.

Pugh, W. S., Jr., P. A. surgeon, detached from the *Dixie* and ordered to duty at the naval hospital, Boston.

Clifton, A. L., asst.-surg., detached from the *Michigan* and ordered to the *Castine*.

Sterne, C. F., asst.-surg., ordered to naval hospital, Las Animas, Colo., for treatment.

Malkin, G. M., A. A. surgeon, detached from the Navy recruiting station, Baltimore, and ordered to the marine recruiting station, Pittsburg, Pa.

Dessez, P. T., P. A. surgeon, ordered to the naval hospital, Boston, for duty.

Ledbetter, P. B., asst.-surg., ordered to the naval hospital, Norfolk, Va., for duty.

Brownell, C. D., surgeon, ordered to duty at the naval hospital, Portsmouth, N. H., when discharged from treatment at the naval medical school hospital, Washington, D. C.

Bogan, F. M., surgeon, detached from the naval hospital, Portsmouth, N. H., and ordered to the *Wisconsin*.

Melhorn, K. C., asst.-surg., detached from the *Dixie* and ordered to the naval hospital, Newport, R. I.

Stone, E. P., medical inspector, detached from the Navy yard, Boston, and ordered to command the naval hospital, Canacao, P. I.

Stitt, E. R., surgeon, detached from command of the naval hospital, Canacao, P. I., and ordered to temporary duty in the bureau of medicine and surgery, Navy department.

Kennedy, R. M., surgeon, detached from the naval station, San Juan, P. R., and ordered home to await orders.

Porter, F. E., P. A surgeon, detached from the naval station, San Juan, P. R., and ordered home to await orders.

U. S. Public Health and Marine-Hospital Service

Changes for the seven days ended June 21, 1911.

Geddings, H. D., surgeon, granted one month's leave of absence from May 23, 1911.

Eager, J. M., surgeon, directed to proceed to Palermo, Italy, for duty in the office of the American consul.

King, W. W., P. A. surgeon, leave of absence for three weeks from April 7, 1911, revoked.

Wille, C. W., P. A. surgeon, granted seven days' leave of absence from June 20, 1911.

McLaughlin, A. J., P. A. surgeon, directed to proceed to certain parts on the drainage basins of lakes St. Clair, Huron and Michigan on special temporary duty.

Mulian, E. H., P. A. surgeon, granted one month's leave of absence from June 24, 1911.

Grimm, R. M., asst-surg., granted seven days' leave of absence from June 14, 1911, under paragraph 191, Service Regulations.

Bingham, E. O., A. A. surgeon, granted fifteen days' leave of absence from June 20, 1911.

Delgado, J. M., A. A. surgeon, granted fifteen days' leave of absence from July 1, 1911.

Mason, W. C., A. A. surgeon, granted nine days' leave of absence from June 21, 1911.

Mazzacarra, R., A. A. surgeon, directed to proceed from Messina, Italy, to Calabria on special temporary duty.

Miranda, R. U. Lange, A. A. surgeon, leave of absence for six months from June 3, 1911, without pay, revoked.

Parker, T. F., A. A. surgeon, granted fifteen days' leave of absence from July 1, 1911.

Pearse, H. E., A. A. surgeon, granted thirty days' leave of absence from June 22, 1911.

Wood, J. E., A. A. surgeon, died June 2, 1911.

Medical Economics

THIS DEPARTMENT EMBODIES THE SUBJECTS OF POST-GRADUATE WORK, CONTRACT PRACTICE, LEGISLATION, MEDICAL DEFENSE, AND OTHER MEDICOLEGAL AND ECONOMIC QUESTIONS OF INTEREST TO PHYSICIANS

A RELIGIOUS NEWSPAPER ON THE BLACK PLAGUE

The growth of enlightened sentiment on public health questions is well illustrated by an editorial in a recent number of the *Congregationalist and Christian World* of Boston, which discusses, simply but forcibly, problems which a few years ago would have been considered unfit for comment on the editorial page of any lay newspaper, least of all a religious weekly. The *Congregationalist* is to be congratulated on its editorial wisdom and fearlessness. May its example be speedily followed by other religious papers! Here is the editorial:

Rhode Island has lately been in a state of panic over the presence of a 14-year-old boy in one of its schools who has been discovered to be a leper. The authorities have strictly quarantined him and sought to make an arrangement that would establish him for life in the Massachusetts leper colony on the island of Penikese in Buzzard's Bay. Every one must be sorry for the boy and his family, and perhaps this plan of exile to the leper colony is the best solution of a difficult problem. On that beautiful island the boy will find the only social group in New England where he will not be regarded with dread and suspicion. There is already there a boy of his own age whose mother has exiled herself, probably for life, to become her son's companion.

Doctors are not in agreement about the contagiousness of leprosy. Many of them maintain that it is not contagious at all, though they are not prepared to account either for its origin or to offer a cure. But there is a disease quite prevalent in Rhode Island and all the other states, which the doctors are all agreed is both contagious and which has been regarded as incurable as leprosy. Yet the victims go about the streets unquestioned and are received in homes, even though the rottenness in their bones shows plainly in the disfigurement of their faces. Their disease is so contagious that it has compelled the disuse of public drinking-cups. It may be caught innocently by the use of a towel or handkerchief after a sufferer, or the touch of a cut place on a hand. Husbands give it to wives and through them to unborn children.

If we are going to segregate lepers in horror of contagion, it is high time we shut up syphilitics in a place where they cannot spread their rottenness. But it would take a larger island than Penikese to hold all these perilous sufferers from blood-poisoning and carriers of contagion.

AN INDEPENDENT EDITOR'S VIEW

In pleasing contrast to the position taken by some newspapers at the command of the interests opposed to public-health legislation, is the attitude of many high-class newspapers of the country, which have opened not only their news-columns but their editorial departments as well, to hearty and unqualified endorsement of the present movement for better health conditions. An excellent example of this class of newspapers is the Berkeley (Cal.) *Independent*, which has recently published a series of articles, discussing the Owen bill and the opposition to it. The *Independent* says that the time is ripe for explaining to its readers just what the National League for Medical Freedom is; for showing, in fact, that its only reason for demanding "medical freedom" is to permit the unhampered continuance of medical fakers, charlatans and health-cure pettifoggers, and that the danger to public health created by such a class is sufficient excuse for discussing the situation. After reviewing the history of the introduction of the Owen bill into congress and the hearings before the committee to which it was referred, the *Independent* says:

There came to the hearings of the committee the representatives of the National League for Medical Freedom with the express purpose of killing the bill by any possible means. The vociferous opposition they raised was enough to deceive any except the most experienced. Any intelligent man knows that the national government has no more control, outside of the District of Columbia, over the practice of medicine than it has over the practice of farming or of law and, although the Owen bill proposed provisions for the prevention of disease, and not its cure, and made absolutely no provision for putting any kind of doctors in authority over any kind of body or thing, yet the practitioners of the homeopathic and eclectic and other schools were gravely informed that the "regulars" were to be in absolute control of homes and families, that even religious liberty was being threatened. The real people back of this clamor made little effort to keep their identity a secret and it soon became known. Among them were the patent-medicine people, the adulterators of food and members of other interests naturally at enmity with pure drugs and pure food and honesty and decency of method in such matters, fearful of every possible curtailment of the millions of yearly income they were deriving from their nefarious trade. They had organized into an unholy and corrupt conspiracy to mislead the people of the United States and to break down the profession which was taking the people's side against them—the American doctor.

After discussing the need of better health legislation the *Independent* concludes:

These, then are some of the men who are opposing the regular physicians of the United States, calling them every possible name that the libel laws will permit, fighting every effort they are making to prevent illness in the United States and to promote healthful conditions. The National League for Medical Freedom is organized to protect its members' pockets, no matter what happens to the people.

Medicolegal

Mining Companies Not Liable for Services Rendered Injured Employees at Unauthorized Requests of Superintendents

The Supreme Court of Florida, Division A, holds, on the appeal of the Atlantic Refining Co. vs. Leffingwell & Berry (54 So. R. 266), that where a corporation operates a mining plant, and does not authorize its superintendents to employ a physician at the expense of the corporation to attend an employee injured by the machinery of the plant, the law does not imply such authority, at least where there is testimony that such authority was not given or contemplated by those exercising the rights of the corporation. The liability of the corporation for negligence that proximately injures an employee may extend to medical services to him, but this does not create a contract liability for such services.

In this case an employee in the mining plant of the company was injured by machinery in the plant, and a superintendent of the mine telephoned to one of the plaintiffs, a physician, to come to the injured man and bring another physician with him. The two plaintiffs went to the place and were met by the superintendent mentioned and another superintendent of the mining plant, who took them to the injured man, and asked them to take charge of him, and the other superintendent asked for a statement of the condition of the injured man to be sent to the home office of the company. The superintendents stated to the physicians that the man was injured by the company's machinery, and requested them to take charge of him, and they attended him after he was removed to his home. In answer to a letter written by the superintendents to the vice-president of the company the latter said that, while the company, as a manufacturer, was not responsible for physician's bills incurred by patients in the treatment of injuries received by accident in its factories, in this particular case the company was willing to pay such bills indirectly; that the company assumed no responsibility even for such bills incurred when in emergency a physician was summoned by the company; that all bills should be rendered to the patient, and the company would advance him such money as was necessary to pay reasonable charges for medical attention, etc.

Under these circumstances, and because in view of the testimony in the case it was not clear that the duties of the superintendents of the mining plant were such that the law implied therefrom authority to employ physicians for the company to attend employees of the company injured by its machinery, a new trial should have been granted, and the judgment obtained by the plaintiffs is reversed. A request of the superintendent to render the medical services was not in law a request of the company, and as a consequence the liability of the company was not shown.

Society Proceedings

COMING MEETINGS

American Ophthalmological Society, New London, Conn., July 11.
Oregon State Medical Association, Los Angeles, Cal., July 10.

LOUISIANA STATE MEDICAL SOCIETY

Thirty-Second Annual Meeting, held at Shreveport, May 30-June 1, 1911

The President, DR. E. J. GRANER, New Orleans, in the Chair

The officers elected were named in THE JOURNAL, June 10, 1911, page 1729.

Cerebrospinal Meningitis

DR. L. G. BEBEUF, New Orleans, reported a case of toxic cerebrospinal meningitis, which was successfully treated with the Murphy drip.

DISCUSSION

DR. L. R. DEBUYS, New Orleans: I have not had any experience with the Murphy drip in cases of cerebrospinal meningitis. I rather approve of doing spinal puncture in all suspected cases of cerebrospinal meningitis. I have never seen any harm done by it, and I think we can gain a great deal of knowledge by it in such cases.

DR. C. C. BASS, New Orleans: The essayist stated that he did not make use of lumbar puncture, and did not give the Flexner serum, but I think it is worthy of emphasis that the Flexner serum for cerebrospinal meningitis seems to be as well established as antitoxin for cases of diphtheria. I do not think anybody should treat a case of meningitis without it. Determine whether or not it is a meningococcic meningitis, and, if so, give the patient the benefit of the serum treatment. The serum treatment is not of service in any other cases except meningococcic meningitis. In the recent outbreak of meningitis that occurred in Mississippi, a striking beneficial effect was obtained in those cases in which the antimeningococcic serum was administered. Not a single patient with meningitis who received the serum died. Three out of four died without the use of the serum, and three out of three lived with the serum. That is in keeping with most of the reports on the use of the Flexner serum.

DR. J. B. ELLIOTT, New Orleans. In the last three or four cases of meningitis I have seen the spinal column was tapped immediately, and the Flexner serum given promptly. You cannot do any harm by administering the serum; it may do good, and it is my practice to tap the spinal column immediately, and then give the Flexner serum. The Murphy drip is the best thing I know of, and when I get a bad case of any kind, I use the Murphy drip with good black coffee, using 3 ounces in ½ pint of normal salt solution.

DR. E. DENEGRE MARTIN, New Orleans: In children it is unnecessary to run the catheter into the intestines any great distance. Two inches is sufficient, because when the catheter is run into the intestine very far it will coil up in the rectum, and if you keep on pushing it long enough it will come back again. Introduce it 2 or 3 inches into the rectum, and hold it there with adhesive plaster, and it will remain as long as the plaster sticks. As to the drip, the vessel containing the fluid should never be raised more than 2½ or 3 inches above the rectum in the case of infants. If it is, the fluid will not be absorbed. It will cause a reflex action of the bowel, and the whole thing will be expelled.

Acute Otitis in Measles, Diphtheria and Scarlet Fever

DR. ARTHUR I. WEIL, New Orleans: In scarlet fever, otitis is much more apt to occur late in the disease during the period of desquamation, consequently it is during convalescence that we must be especially on our guard for the signs of beginning otitis. The otitis of scarlet fever is more severe than that accompanying the other two diseases, although the same rule holds good here as in the others, that the virulence of the otitis is proportional to the virulence of the causative disease. The ear complications of diphtheria fall naturally under four heads: 1. Diphtheritic inflammation of the external auditory canal. 2. Affections of the internal ear, usually a nerve deafness, somewhat analogous to postdiphtheritic paralysis of the soft palate, and other neuroses produced by the general toxemia of the disease. 3. Diphtheritic inflammation of the Eustachian tube and middle ear. 4. Acute catarrhal or purulent inflammation of the middle ear without the formation of membrane. This is in no sense different from the otitis caused by scarlet fever or measles. The scarlet fever otitis is the most fulminating and causes more danger to life and hearing. Next in order is diphtheria, and lastly measles. The chief danger to life is caused by extension to the meninges, the brain and thrombosis, with subsequent septicemia and pyemia. The hearing is threatened probably through involvement and necrosis of the internal ear, complete absorption of drum membrane with the ossicles and caries of the surrounding bone. The otitis becomes chronic with constant suppuration and is a menace to the remaining hearing throughout the life of the patient until a radical operation is performed.

The Dyspepsia of Phthisis

DR. J. A. STOECK, New Orleans: The lungs of every young person who suffers from a persistent dyspepsia should be examined. Derangements of digestion are a common accompaniment of tuberculosis, and present one of the greatest difficulties in its treatment. The success of the fight in a given case of tuberculosis depends on the integrity of the digestive system, and therefore it should be given the most careful attention. The management and therapy of the case should deal with the primary disease. A very full rich diet should be insisted on in spite of the dyspeptic complaints. Hansmann has pointed out the importance of examining the empty stomach in the morning for tubercle bacilli, as often they are found when no chest symptoms are manifest, tubercle bacilli having been swallowed during the night. The appetite does not always correspond to the gastric findings. The cases in which free HCl is normal or in excess, are as a rule, free of fever. Motor function is very little impaired in initial stages but is reduced in later stages. In the beginning the secretory power of the stomach is usually increased, often normal, and rarely reduced. In the terminal stages it is always greatly reduced. The dyspepsia of early phthisis belongs chiefly to the group of anemic-enteroptotic dyspepsias. Nausea and regurgitation, which frequently occur after meals, should not be given too much attention. Only when cramp-like pain and diarrhea set in should the amount of food be lessened, and the diarrhea properly treated. Constipation is often best corrected for the time being with magnesium sulphate or castor oil. Massage of the stomach and also of the intestines affords considerable relief during the rest cure. Suitable support by adhesive plaster belt or properly fitting abdominal supporter is indicated when ptosis of the viscera exists. Symptoms should be treated as they arise, and indications for acid, iron, belladonna, etc., met. Alcohol should positively be avoided. Almost every case of tuberculosis sooner or later shows some disturbance of the digestive organs. It is understood that the care of these patients is to be that of every well-treated case of tuberculosis of the lungs. Dyspepsia appears more frequently among women than among men. Women are more frequently affected with flatulence and vomiting and men with pain and acidity. The most typical instances of dyspepsia are encountered in that variety of pulmonary tuberculosis which commences insidiously and progresses slowly.

Toxemia of Pregnancy; Its Cause, Nature and Treatment

DRS. O. W. COSBY and R. H. BLACKMAN, Monroe: Nearly all the symptoms incident to pregnancy from simple morning sickness to pernicious vomiting, and eclampsia, are only varying degrees of toxemia. This toxemia is due to suboxidation, or unoxidized substances, principally of the nitrogenous derivative, in the circulation. Urea and uric acid are harmless end products, which can be eliminated as such without trouble, but it is only when the nitrogenous particle is incompletely oxidized, leaving bodies, such as xanthin, hypoxanthin, am-

monia, creatin, etc., that toxemia begins. Both the urinary and the autopsy findings show that the toxemia of pregnancy is the same condition as auto-intoxication of the non-pregnant individual. The pregnant woman is more prone to this autotoxemia because of the increased katabolic activity, more sedentary habits, and because of the increased demands for oxygen on account of its fetus. Oxidation is brought about, governed and controlled by the adrenal system, and the thyroid secretes a fluid which stimulates the adrenal activity, thereby increasing oxidation, as witness the physiological enlargement of the thyroid, in normal pregnancies, to meet the demands on it for increased oxidation, and as shown by Charles Mayo, when this enlargement does not occur, the woman is in danger of eclampsia. The internal secretion of the adrenal is the constituent of the hemoglobin molecule, which carries oxygen to the tissues, and in cases of suboxidation or adrenal insufficiency, and amelioration of the condition, and a cessation of symptoms, or an increased adrenal activity, can and is brought about by administering thyroid extract.

Veratrum viride is the very best remedy we have in eclampsia for lessening the irritability of the vasomotor center, lowering vascular tension, and relieving the attack. Chloroform is not safe, on account of its liability to produce degenerative changes in the liver, and morphin is only an artificial remedy, which should never be used when there is any kidney disease, or diuresis is not free. Chloral, and the bromids when used in large enough doses to control the convulsions, act similar to, but are not as desirable as veratrum. Elimination combined with the above means and lessened proteid ingesta are the only rational methods of combating this toxemia. Physiologic saline solution, preceded by venesection in suitable cases, is one of the safest as well as the surest means of preventing eclampsia, during the pre-eclamptic period, as well as controlling and relieving the seizure. It is the duty of the physician in every case of pregnancy in which he expects to act as accoucheur, to inform the patient of some of the dangers incident to pregnancy, to give her full and minute instructions in regard to her diet, exercise, elimination, etc.; also to examine a twenty-four-hour specimen of urine every four weeks during the first six months, and every two weeks after that, not only for albumin but more especially for the total nitrogen, amount of urea, casts, etc., and when evidence is found that elimination is checked, to put the patient on an absolute milk diet, plenty of water and administer thyroid extract to increase the adrenal activity and oxidation. For two years we have used thyroid extract with the elimination measures outlined, in all degrees of toxemia, or adrenal insufficiency, with the most happy results.

A Plea for the Proper Feeding of Infants

DR. C. H. RICE, New Orleans: I wish to call attention to the new method of percentage feeding. At first, I watched with considerable skepticism the milk formulæ that were written out in the pediatric clinic of New Orleans for the cases of malnutrition; but when the infants showed a gain of 2 to 6 ounces a week, my skepticism vanished, as did the mystery of it. The pediatrists are doing in a careful scientific manner just what the old woman did with her blind instinct. They are supplying in sufficient amounts the food ingredients that these starving infants need. By diluting the milk, or cream, and adding milk sugar they are adjusting the fats, carbohydrates and proteins, according to the weight, age and digestion of each infant. The results obtained in these clinics last summer were excellent. A majority of the infants that remained under observation regained their loss in weight and had no further trouble. Some of the others remained underweight, but managed to live through the hot months without any digestive disturbances. In my own clinic the results obtained by this method have been so satisfactory, so far in excess of those from the old methods that I am convinced that the time has come when all of us who treat children must cast aside our ancient and unprogressive ideas about infant-feeding and adopt that method.

(To be continued)

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

Annals of Surgery, Philadelphia

June

1 Large Intrathoracic Cysts of the Thyroid Causing Dyspnea. W. Martin, New York.
2 *Anesthesia by the Intratracheal Insufflation of Air and Ether. C. A. Elsberg, New York.
3 Laminectomy for Injury and Tumor of the Spinal Cord. G. P. Muller, Philadelphia.
4 *Organoscopy. B. M. Bernheim, Baltimore.
5 Treatment of Chronic Pancreatitis by Pancreatostomy. G. Link, Indianapolis.
6 Acute Hepatitis Simulating Stone in the Common Duct and Liver Abscess. J. W. Churchman, Baltimore.
7 *Rational Treatment of Acute Appendicitis. J. B. Deaver, Philadelphia.
8 *Chronic Appendicitis. E. MacD. Stanton, Schenectady, N. Y.
9 *Surgery of the Ureter. G. E. Brewer, New York.

2. **Intratracheal Insufflation Anesthesia.**—Elsberg has found this anesthesia very useful in operations on the neck, such as thyroidectomy. In the first place the anesthetizer is away from the field of operation. More important, the operator can manipulate the trachea as much as necessary without causing disturbance in breathing or interference with the anesthesia. Nor need he fear a sudden collapse of the trachea in the course of the removal of a large goiter; the presence of the tube in the trachea will guard against such complications. He believes that insufflation anesthesia should be very valuable in the operation of laryngectomy, but he has not yet had the occasion to perform a laryngectomy under insufflation anesthesia. The method of anesthesia is of great value in operations on the tongue and mouth and in operations on the superior and inferior maxilla, in which the buccal cavity or pharynx has to be widely opened. There is no danger of aspiration of blood into the lungs, and tamponade of the larynx is unnecessary. No blood can run down into the trachea. The current of air which is continually flowing upward in the trachea by the side of the tube will blow out all of the blood which tends to run down into the larynx and trachea. The anesthesia should be useful in those operations in which the patient has to be placed flat on the abdomen. Thus, it should be advantageous in those operations on the brain and the spinal cord, such as bilateral suboccipital craniotomy and laminectomy, in which the patient has to be in the prone position and in which the giving of the anesthesia is ordinarily difficult.

4. **Organoscopy.**—Bernheim feels that the results obtained by him with Jacobeus' method of visual inspection of the abdominal organs in two cases were sufficiently encouraging to warrant a further trial.

7. **Acute Appendicitis.**—Deaver says, in concluding his paper, that if there is one fact in the field of medicine which has been demonstrated conclusively, it is that the rational treatment of acute appendicitis is in operation, early and immediate, if possible; late, postponed, or absolutely contra-indicated only by the presence of other conditions which may be complications of the disease itself or entirely independent of it, mere coincidences which render the performance of any operation too hazardous.

8. **Chronic Appendicitis.**—In Stanton's experience the majority of patients suffering from chronic appendicitis give a history of having had one or more attacks of acute abdominal illness, with a sequence of symptoms recognizable as those of an acute appendix attack, namely, sudden severe abdominal pain, usually beginning in the epigastrium or mid-abdomen, accompanied by nausea and vomiting and followed by a period of pain and tenderness in the right lower quadrant. In his experience, further, appendiceal dyspepsia has been characterized by symptoms strikingly analogous to the earliest symptoms of acute appendicitis, namely attacks of epigastric or mid-abdominal pain or distress only rarely accompanied by subjective symptoms referable to the region of the appendicitis. During these attacks the pain or distress is nearly always increased by food intake. Pain confined chiefly to the right lower quadrant and not associated with attacks

of epigastric pain and nausea is seldom due to the appendix, and before making a diagnosis of chronic appendicitis in these cases every other possible condition should be excluded. The majority of our failures have been in patients complaining of right inguinal pain associated with chronic constipation. At operation these patients have presented an unusually long or dilated cecum, usually accompanied by other evidences of enteroptosis. In the future a certain proportion of these patients may be cured by some such operation as that advocated by Wilms, but appendectomy alone does not cure. Unless the diagnosis is absolutely certain, the gall-bladder, stomach and right kidney should be explored, and the possibility of Lane's kink excluded in all cases operated on for chronic appendicitis.

9. **Surgery of Ureter.**—In reviewing the histories of thirty-three cases, Brewer says that the majority of his mistakes in diagnosis were made in cases supposed to be calculus. There were six of these. In three, other lesions were found which were sufficient to account for the symptoms. In the remaining three no lesions were found to account for the symptoms, although an extra-ureteral calcarous body was found in one instance, which gave rise to the shadow in the skiagraph, and in another there was reason to believe that a stone was present at the time of the examination, which passed before the ureter was opened. Of his three other mistakes in diagnosis, two were in mistaking a ureteral calculus for a lesion of the vermiform appendix, and one in mistaking a ureteral calculus for intestinal obstruction. In none of these cases did he have the aid of cystoscopy or radiography. Only one death occurred in the series, and that was a traumatic case which was moribund at the time of admission, and in which nothing was done other than to check the hemorrhage by gauze packing. Of fifteen cases in which the ureter was exposed, opened, and subsequently sutured, all healed without infection and without leakage of urine. The same may be stated in regard to two cases in which a ureteral calculus was removed through an opening in the bladder.

16. **Rabies in Philippine Islands.**—The prophylactic treatment against rabies, advocated by Ruediger, consists of twenty-five subcutaneous injections, one of which is given each day, hence the course of treatment covers twenty-five days. Injections should be made in the back or in the abdominal wall, not in the arms or legs. Material for injection is furnished by the Bureau of Science in Manila, in bulbs containing one dose each; the bulbs are numbered from 1 to 25, indicating the order in which they are to be used. On the first day of treatment inject the contents of Bulb 1; on the second day inject the contents of Bulb 2, and so on until the twenty-five doses have been given.

New Mexico Medical Journal, Las Cruces

May

10 Cases of Intestinal Obstruction. J. Vance, El Paso, Texas.
11 Influence of Altitude on Heart Disease. S. D. Swope, Deming.
12 Modern Practice. M. D. Walsh, Pena Blanca.
13 Acute Suppuration of the Middle Ear. D. D. Swearingen, Clovis.
14 Diagnosis of Cancer of Stomach. E. C. Prentiss, El Paso, Texas.
15 Lymphatic Leukemia. R. E. McBride, Las Cruces.

Bulletin of the Manila Medical Society, Manila, P. I.

April

16 *Rabies in the Philippine Islands and Method Available for Controlling It. E. H. Ruediger, Manila.
17 *Five Hundred Cases of Peritonitis. H. Schmid, Manila.
18 Technic of the Surgical Clinic of the Philippine General Hospital, Manila. J. R. McDill and H. E. Schiffbauer, Manila.

17. **Peritonitis.**—The material which is the basis of Schmid's paper consists of all cases of diffuse peritonitis operated in Koerse's clinic in Berlin, between 1890 and 1910. During this time they had among 1,258 perityphlitis cases, 22.2 per cent. peritonitis. This percentage may appear very high, but we must not forget that during the first years of the compilation of the statistics, the operation of perityphlitis was practically unknown. To find out the best time for the operation, Schmid compiled the results of the days on which the operation had been performed after the beginning of the disease. On the first day of disease, operated on 29, recovered 26, fatal 3, mortality 10.3 per cent.; on the second day of disease, operated on 89, recovered 70, fatal 19, mortality 21.3 per cent.; on the third day of disease, operated on 67, recovered 46, fatal 21, mortality 31.3 per cent.; on the fourth day of disease, operated on 174, recovered 71, fatal 103, mortality 59.1 per cent. This shows that the mortality increases the longer the duration of the disease. The conclusion is obvious that every appendicitis which shows only the slightest symptoms of peritonitis should be operated on. The technic of the operation must be adapted to the cause of the peritonitis. In most of the cases, Schmid says, it will be possible to determine diagnostically the point of origin of the peritonitis, and under these circumstances one must cut so as to reach this point at once. His method is: In appendicitis due to peritonitis make a long cut following the margin of the os ilei, dissecting the muscles sharply with the knife. After the removal of the appendix all parts of the peritoneal cavity are carefully examined and all adhesions carefully separated. Now wash with warm normal salt solution and place a drain in the place of the resected appendix. Very often the question has been discussed whether it is advisable to wash the peritoneal cavity or not. Schmid has compared the mortality of those cases in which they cleansed the peritoneum with absorbent gauze with those in which they irrigated. The difference is very small. In the washed cases there was 40 per cent. and in the others 42 per cent. mortality. However, he qualifies that it may be due to the fact that they always applied the irrigation in more severe cases while in the mild ones the patients were sponged. Excluding the patients treated within the first three days the mortality is 55.4 per cent. for the irrigated and 69.2 per cent. for the sponged ones. Still greater is the difference in children. The cases of peritonitis in children irrigated gave a mortality of 40.5 per cent., the sponged ones, 68.7 per cent. Of ten patients with perforated stomach ulcer, operated after the first day, only one recovered. Patients operated during the first twelve to twenty-four hours gave a mortality of 25 per cent., while no patients died if operated within the first twelve hours. Generally speaking, Schmid believes that the prognosis of peritonitis caused by a perforation in the digestive tract is worse the lower the perforation. Perforation of an infected gall-bladder gives a mortality of 50 per cent. He regards as the main reason for this high mortality the fact that patients with a perforated gall-bladder are usually weakened by long sickness. The cases of peritonitis resulting from the female sexual organs gave the high mortality of 64.7 per cent. The explanation of this remarkably high figure is said to be the fact that only the most severe cases of this class of peritonitis are operated by the surgeon, most of them being treated expectantly. Schmid does not believe in operating on puerperal peritonitis, because general sepsis seems to be the danger.

Journal of the Kansas Medical Society, Kansas City

May

19 Injury to the Eye. H. W. Woodruff, Joliet, Ill.
20 Eyes and Ears of School Children. H. B. Caffet, Pittsburg.
21 Varicose Veins. N. C. Morrow, Altamont.
22 Diagnosis and Treatment of Ulcer of Stomach. P. T. Bohan, Kansas City, Mo.
23 Post-Operative Thrombosis and Neuritis. S. Cooper, Fort Smith, Ark.
24 Ankylostomiasis. F. W. Tretbar, Stafford.

American Journal of Diseases of Children, Chicago

June

25 *Diagnosis of Infantile Tetany. H. B. Wilcox, New York.
26 *Hexamethylenamin in Influenzal Meningitis. W. V. Brem and A. H. Zeller, Cristobal, Canal Zone.
27 *Blood in Pertussis. J. A. Kolmer, Philadelphia.

25. **Diagnosis of Infantile Tetany.**—In Wilcox's series of 318 electrical tests on 118 infants, 10, or 3.1 per cent., gave evidence of extreme or kathodal hyperirritability. Of the middle grade or anodal irritability giving response to kathodal closure and anodal closure alone below 5 milliamperes, there were 101, or 31.8 per cent. With kathodal closure and anodal opening alone present, below 5 milliamperes, he found fifty, or 16.6 per cent. With both kathodal closure, anodal closure and anodal opening, less than 5 milliamperes, there were forty, or 12 per cent. The occurrence, then, in his series of abnormal reaction or increased electrical response according to Each-

erich's definition was 193, or 61 per cent. Of these cases of anodal or partial hyperirritability none developed other symptoms of tetany under observation. The incidence of partial hyperirritability in children under 5 pounds was 16 per cent.; 5 to 10 pounds, 22 per cent.; 10 pounds and over, 30 per cent. With reference to change in weight or, as this is its best index, the general condition of the subjects, it was found that of sixty children losing weight, 25 per cent. showed partial hyperirritability; of the twelve with stationary weight, 16 per cent. showed partial hyperirritability; and of the twenty-seven gaining weight, 37 per cent. showed partial hyperirritability. During the period of this work there were fifty-seven infants on skim-milk mixtures, twenty-one on condensed milk, twenty-three on butter-milk, eighteen on Finkelstein's "Eiweismilch," fourteen on whole-milk mixtures and twenty-four were on the breast. As it has been shown that tetany occurred more frequently in the artificially than in breast-fed children, comparisons between the reactions of these classes were made. In the breast-fed the average of kathodal closure, 3.2 in thirty-eight tests; anodal closure, 4 in twenty-four tests; anodal opening, 4 in seven tests; and kathodal opening, 2.4 in one test, were practically the same as those for artificial feeding, which were: kathodal closure, 2.8 in 172 tests; anodal closure, 3 in 123 tests; anodal opending, 4 in sixty tests; and kathodal opening, 4 in nine tests. Taking the number of breast and artificially fed children who showed distinct hyperirritability, it appears that there was none of the ten former, but 24 per cent. of the 108 of the latter class. It must be added, however, that the cases were not exclusively on either type of nourishment for a great length of time before testing. Of thirty-eight instances of good gastric digestion 30 per cent. showed hyperirritability; of fifty-eight instances of poor gastric digestion 30 per cent. showed hyperirritability; of twenty-seven instances of good intestinal digestion 33 per cent. showed hyperirritability; of seventy-seven instances of poor intestinal digestion 24 per cent. showed hyperirritability.

26. **Hexamethylenamin in Influenzal Meningitis.**—Two patients, 18 and 23 months old respectively, with meningitis caused by a bacillus culturally like *B. influenza* were treated by Brem and Zeiler with large doses of hexamethylenamin without apparent benefit. Both infections terminated fatally. Late in the course of the disease in the second patient, while hexamethylenamin was being given, a needle was inserted into the spinal canal in the lumbar region and was left in situ in the hope of securing permanent drainage. Immediately afterward the temperature dropped practically to normal and remained normal for about twenty-four hours, when it rose again. It was found that the needle had worked out and drainage had ceased. The authors state that the combination of permanent drainage and hexamethylenamin treatment may be of value in treating those cases of meningitis for which we have no specific treatment.

27. **Blood Examination in Pertussis.**—Out of the thirty-seven cases of cough which could not be diagnosed clinically from pertussis in the catarrhal stage, observed by Kolmer, sixteen proved later to be pertussis. Of these, thirteen, or 81.25 per cent., had been diagnosed correctly by means of the blood examination. Three, or 18.75 per cent., were given an incorrect diagnosis. Of the twenty-one cases proving not to be pertussis, fifteen, or 71.4 per cent., were given the correct, and six, or 28.6 per cent., the incorrect diagnosis. Kolmer cautions that the presence of secondary infection which may by itself produce leukocytosis with a relative or actual decrease of the small lymphocytes, will lead to error. In such cases it is better to be guided by the total number of leukocytic elements in the c.c. of blood rather than by percentages.

Yale Medical Journal, New Haven, Conn.

April

28 The Roentgen-Ray as an Adjuvant in the Treatment of Cancer. C. E. Skinner, New Haven, Conn.
29 Treatment of Youthful Tendencies to Functional Nervous Disorders. C. A. McKendree, Cromwell, Conn.
30 Functional Ear Tests. C. Weidner, Hartford, Conn.

Albany Medical Annals, Albany, N. Y.

June

31 Discovery of the Tubercle Bacillus. A. T. Laird, Albany, N. Y.
32 Clinical Experiences with the Wassermann-Noguchi Test. J. N. Vander Veer, Albany, N. Y.
33 Surgical Sequels of Acute Anterior Poliomyelitis. J. B. Garlick, Schenectady, N. Y.
34 *Electrical Remedies for High Arterial Tension. H. W. Van Allen, Springfield, Mass.
35 Right-Handedness and Left-Handedness. I. Hartshorne, Poughkeepsie, N. Y.

34. **Electrical Remedies for High Arterial Tension.**—Allen claims that high frequency currents, as auto-condensation, reduce blood-pressure by removing the exciting cause; prevent auto-intoxication, and relieve diabetic conditions. Fulguration removes moles and small questionable epithelioma and can be used in the bladder. Heat penetration causes increase of heat at a distance from the point of application and therefore relieves in joint conditions, contusions and non-malignant exudates.

Journal of the South Carolina Medical Association, Charleston

May

36 *Imperative Necessity for Proper Drainage of Our Water Courses and Low Lands. J. H. McIntosh, Columbia.
37 Treatment of Lobar Pneumonia. J. D. Wilson, Lowndesville.

36. Abstracted in THE JOURNAL, June 3, 1911, p. 1678.

Wisconsin Medical Journal, Milwaukee

May

38 Early Diagnosis of Cancer. F. G. Connell, Oshkosh.
39 Aneurism of Descending Thoracic Aorta. J. F. Smith, Wausau.
40 Plaster Spica in High Fractures of Femur. C. H. Lemon, Milwaukee.
41 *Olive Oil in Treatment of Ulcer of Stomach. O. Lotz, Milwaukee.
42 *Relation Between Splanchnoptosis and Pulmonary Tuberculosis. W. Becker, Milwaukee.

41. **Olive Oil in Treatment of Gastric Ulcer.**—Two patients with intractable recurrent gastric ulcer, which seemed to have as a more or less exciting factor a marked hyperacidity, apparently recovered from the acute condition under the use of rest, dietetic measures, bismuth and alkalies, but so soon as these were discontinued the old symptoms of hyperacidity would return, while the general nutritive condition of the patient was not much improved. Lotz then resorted to the use of olive oil before meals. The results in both cases were exceptionally gratifying, and the oil treatment was used by Lotz in all cases of gastric ulcer and hyperacidity, only to find out the truth of the old story that after all the patient must be treated, and not so much the condition. There is no doubt as far as the diagnosis is concerned, as all the cardinal symptoms of gastric ulcer, characteristic pain, tenderness, vomiting and hemorrhage were present. It has been Lotz' experience that a large majority of the patients suffering from hyperacidity and chronic ulcer of the stomach give a history of a gradual loss in weight, extending over a long period of time, and frequently present themselves in a nutritional condition far below par. Besides this, a history of chronic constipation is in this class of cases very conspicuous, while signs of secondary anemia are likewise of common occurrence. Without exception all of the ulcer patients, under the use of pure olive oil, a liberal diet, and somewhat regulated mode of life, gained rapidly and steadily in weight, some of the signs of anemia disappeared, while the constipation ceased to be an annoying factor. Furthermore, up to the time of writing, so long as these patients have retained their normal weight, no symptoms of gastric hyperacidity have appeared. Taking these results as a working basis, Lotz asks, could it not be possible that the persistent hyperacidity, which has at the present time an unknown etiology, is due to the presence of a so-called vicious circle, the hyperacidity preventing normal digestion and assimilation, with chronic constipation, anemia and poor nutrition as resulting conditions, while these some conditions in their turn act as exciting factors in maintaining the hyperacidity. The continued use of olive oil before meals, Lotz believes, is an effective method of breaking into the vicious circle. By holding in check the excessive secretions of acids for the time being, the oil permits of a liberal diet as soon as pain and tenderness have more or less disappeared.

It of itself has a high nutritive value, and finally, with very many patients, the olive oil acts sufficiently as a laxative to keep the bowels in a normal, regular condition.

42. **Splanchnoptosis and Phthisis.**—Becker states that the phthisical habit and asthenia universalis (splanchnoptosis) are identical. Hence the phthisical habit is not a specific phthisical inheritance. Stiller's costal stigma is a constant concomitant of the same, indicating its presence, but not its degree. Stiller's costal stigma, being a congenital defect, and present in earliest infancy, can, therefore, be considered a diagnostic feature of the habitus phthisicus (so-called) long before phthisis has developed. Diagnosis of asthenia universalis offers great opportunities of combating the congenital disposition to tuberculosis.

Northwest Medicine, Seattle, Wash.

May

43 Value of Indican and Bile Tests in Diagnosis of Abdominal Diseases. G. G. Baar, Portland, Ore.
44 Consideration and Importance of Early Recognition of Erysipelas: Mistakes in Diagnosis. H. E. Robinson, American Fork, Utah.
45 Eyes and Ears of School Children. F. A. Kiehle, Portland, Ore.
46 Middle-Ear Disease in Children. N. P. Wood, Seattle, Wash.
47 Medical Inspection of Schools. N. L. Thompson, Everett, Wash.
48 Follies, Legal and Otherwise, Concerning Our Medical Practitioners. J. C. Robison, Cedar City, Utah.
49 Pemphigus. L. Buck, Portland, Ore.
50 Sterility. D. F. Donnelly, Portland, Ore.

St. Paul Medical Journal

June

51 Septic Endocarditis. T. W. Stumm, St. Paul.
52 Recent Progress in Pediatrics Relative to Digestive Tract. W. R. Ramsey, St. Paul.
53 *Magnesium Sulphate in Tetanus. C. J. Holman, Mankato, Minn.

53. **Magnesium Sulphate in Tetanus.**—Holman reports one case in which the injection of a 12.5 to 25 per cent. solution of magnesium sulphate at various intervals in doses of from 10 to 12 c.c. resulted in recovery.

Detroit Medical Journal

May

54 Pathology of the Derivatives of the Primitive Foregut in the Living. G. V. A. Brown, Detroit.
55 Treatment of Chronic Constipation. L. J. Hirschman, Detroit.

Archives of Diagnosis, New York

April

56 Alleged Pulmonary Tuberculosis; Differential Diagnosis. A. Jacobi, New York.
57 Tuberculous Toxemia. A. C. Wiener, Chicago.
58 Diagnosis of Some Uncommon Intra-Abdominal Conditions in Early Life. G. R. Pisek, New York.
59 The Cellulose Test in the Diagnosis of Ulcer of Stomach. H. W. Soper, St. Louis.
60 *Value of the Glycyltryptophan Test. G. A. Friedman, New York.
61 *Diagnosis of Fibrillation of the Auricle. L. F. Bishop, New York.
62 Diagnosis of the Extra-Genital Chancre. W. S. Gottheil, New York.
63 *Causation of High Blood-Pressure in Cases of Auto-Intoxication. H. B. Hiatt, Ashboro, N. C.
64 *Exophthalmos, A Common Symptom of Chronic Bright's Disease. H. C. Gordinier, Troy, N. Y.

60. **The Glycyltryptophan Test.**—Friedman concludes that even though the glycyltryptophan test was positive in many of his cases of gastric cancer, it cannot be looked on as a reaction pathognomonic of the disease.

61. **Fibrillation of Auricle.**—Attention is called by Bishop to auricular fibrillation, a condition which, he says, can be diagnosed with as much certainty without apparatus as can many other clinical conditions, but tracings afford the complete proof.

63. **Blood-Pressure and Auto-Intoxication.**—The belief of Hiatt is that the rise in blood-pressure in cases of auto-intoxication is caused primarily by the action of these poisons on the smaller ganglionic endings of the splanchnic nerves in the vessel walls, and these poisons have a selective action for the vasoconstrictor nerves. The first effect of this action is a rise in the blood-pressure of the portal vessels. The connection of the nerves supplying these vessels is such that there is a general reaction. An efferent impulse is sent out to the entire vascular system from the reflex centers located in the spinal cord. This will result in acceleration of the heart beat, both through the sympathetic ganglia and the accelerator nerves of the heart. Another factor in the faster beat is local, and is dependent on primary irritation of the heart. Thus we have a faster beat and we have an increased peripheral resistance; these two factors will raise the pressure to an extent that will require a more forceful beat to overcome it. This more forceful beat in the presence of the conditions mentioned will cause a rise in pressure and thus a vicious circle is established.

64. **Exophthalmos a Symptom of Bright's Disease.**—The common occurrence of exophthalmos and the associated external ocular signs in chronic nephritis, are by Gordinier considered important signs in chronic Bright's disease. During the past year he has studied twenty-eight cases of chronic nephritis, two of the chronic parenchymatous type and twenty-six of the chronic interstitial form. Of this number fourteen presented exophthalmos of varying degrees, together with one or more of the associated ocular manifestations. The two cases of large white kidneys presented a marked degree of exophthalmos. They were observed late in the disease suffering with marked renal and cardiac insufficiency and uremia. The cases of the chronic interstitial type of nephritis—twenty-six in number—all presented hypertension, left-sided, and occasionally right-sided cardiac enlargement, with accentuation of the aortic and occasionally of the pulmonic second sounds and the urinary findings that exist in this type of disease. Of this number twelve presented exophthalmos, von Graefe's and Stellwag's sign, and seven the sign of Moebius. In three cases the pupils were irregular. In five cases the exophthalmos seemed more marked on one or other side. In two of the cases the enlargement was greater on the left side, and in three on the right. In none of the cases that have come under his observation was the thyroid gland visible or palpable. The exophthalmos, although most marked in the advanced cases suffering from serious toxemic manifestations, was distinctly visible in those of a less advanced type with fairly compensated hearts and without distinct uremic manifestations. In five of the twelve cases with exophthalmos, albuminuric retinitis was present, and in six cases, arteriosclerotic changes in the vessels of the retinæ with hemorrhages were observed. In none of the cases was tachycardia a prominent symptom. Gordinier believes that the most probable explanation of the exophthalmos and associated ocular signs in chronic nephritis (von Graefe, Stellwag and Moebius) is an irritation of the cervical sympathetic system of fibers by toxins floating in the blood-stream the result of a chronic renal insufficiency.

Denver Medical Times and Utah Medical Journal

May

65 Inflammations of the Conjunctiva and Cornea of Tubercular Origin. E. O. Sisson, Denver, Colo.
66 A Case of Suppurating Appendicitis with Subnormal Temperature and Slow Pulse. H. S. Shafer, Denver.
67 Baptisin. H. H. Redfield, Chicago.
68 The Serum Reaction for Syphilis. S. Simon, Denver.
69 A Glowing Tribute to the Stimulating Properties of Alcohol. J. M. Shaller, Denver.
70 Medicolegal. E. S. McKee, Cincinnati.
71 Nervous Symptoms of Arteriosclerosis and the Removal of the State Causing Them. T. A. Williams, Washington, D. C.
72 *The Medical Profession Must Change Its Tactics. W. J. Robinson, New York.
73 The Police Power in the Light of Constitutional Inhibitions. E. C. Ashton, Salt Lake City, Utah.

June

74 *A Few Odd Things Found at Operations. J. M. Perkins, Denver.
75 How Some Oriental Countries Dispose of Their Dead. C. F. Shollenberger, Denver.
76 *Rubberized Open Meshed Net as a Retaining Dressing in Skin-Grafting. C. E. Tennant, Denver.
77 Reconsideration of Prostate Gland. W. M. Spitzer, Denver.
78 Nitrous Oxid and Oxygen—General Anesthetic. J. W. Seybold, Denver.
79 Nuptial Contamination and Its Remedy. G. H. Bogart, Brookville, Ind.
80 The Stomach-Laboratory Diagnosis. E. S. Budge, Logan, Utah.

72. Also published in the *Detroit Medical Journal*, February, 1911, and in THE JOURNAL, Jan. 14, 1911, p. 138.

74. **A Few Odd Things Found at Operations.**—The first of Perkins' patients operated on for strangulated bowel had been

operated three months previous for appendicitis. On opening the abdomen Perkins found large and small bowel both caught under a band of bowel. On tracing this band up he found it came to a point where it adhered to the mesentery. It proved to be a blind pouch coming off from the small intestine, of the same coating and caliber as the intestine. In the second case, that of a patient operated on for appendicitis, Perkins found a sloughed hole in the appendix about the middle, with two hard concretions of fecal matter about the size of peas, by the opening in the free abdominal cavity, also pus in the free abdominal cavity; and crawling across the ascending colon he found a worm of the lumbricoid variety, which had escaped through the hole into the abdominal cavity. In the third case, a patient operated on for chronic appendicitis, there was a history of having a severe attack of pain some weeks before, which was diagnosed by the family physician as gall-stone colic. After removing the appendix, Perkins found it contained a small gall-stone with polished edges. In the fourth case the appendix contained a single grape seed.

76. **Rubberized Net as a Dressing in Skin-Grafting.**—After all the grafts have been placed and are ready to be fixed in position, Tennant applies a loose meshed bandage which has previously been prepared by immersing for twelve hours in a solution of rubber-tire cement diluted with benzine or gasoline, then dried and sterilized by boiling. The approximate end of the bandage is first tacked to the skin in several places with adhesive tape to avoid slipping of the bandage while it is being wound about the limb. Two or three complete laps are usually made, the ordinary gauze and cotton dressings applied, and the part enclosed in the bandage. The outer dressings may be removed at any time without disturbing the grafts or granulations underneath, and since the dressing is porous and the fabric impervious, it permits of the free escape of discharges, which may be washed from time to time without disturbing the surface underneath. This net remains in position until the grafts are thoroughly healed—from ten days to two weeks. If necessary or desired, windows may be cut away from certain portions of the dressing without interfering with its effectiveness or disturbing the grafts.

81. **Examination in Heart and Blood-Vessel Diseases.**—Bishop claims that it may be said, in general, that the indications disclosed are nearly always the regulation of cardiac functions, rather than stimulation. Weakness indicates either a depressed activity of the heart, which may be, on the whole, conservative, or exhaustion of the reserve of the heart, which renders stimulation a desperate resource. An exhausted heart needs rest, not stimulation. It may be necessary to overcome a loss of tonicity in the heart muscle by digitalis, but that is not stimulation in the true sense, and in some cases of chronic heart disease it may be best to continue its use almost indefinitely, but, where possible, improvement of condition by proper diet, exercise, and conservation of energy should replace drug treatment. The history of the patient could influence judgment much in the advice one could give him, as would also the patient's personality and the measure of his resources.

83. **Stethoscopic Examinations.**—Abrahams, in his defense of the stethoscope, says that while all other instruments may come and go, the stethoscope will forever remain the handiest, readiest and most trustworthy tool of the work-a-day practitioner.

New York Medical Journal

June 10

81 *A Review of Methods of Examination in Heart and Blood-Vessel Diseases. L. F. Bishop, New York.
82 A Polygraphic Machine, Recording Automatically. T. E. Satterthwaite, New York.
83 *Stethoscopic Examinations. R. Abrahams, New York.
84 *Circulatory Disturbances of Mesenteric Blood-Vessels. H. D. Collins, New York.
85 Radiographic Examination of the Gastro-Intestinal Tract. R. H. Boggs, Pittsburg, Pa.
86 *Destruction of Surface and Cavity Neoplasms by Desiccation. W. L. Clark, Philadelphia.
87 Diseases of Occupation. M. Korshet, Passaic, N. J.
88 Involvement of Trachea, Lungs and Pleura in Grippe. R. E. Coughlin, Brooklyn, N. Y.
89 Kidney Infections of Pregnancy. L. Louria, Brooklyn, N. Y.

June 17

90 Prescriptions Old and New. J. J. Walsh, New York, and J. P. Walsh, Philadelphia.
91 Twilight Talks with the Doctor. G. F. Butler, Chicago.
92 Effects of Certain Chemicals on the Type of Tissue, Resulting from Chronic Irritation. G. L. Rohdenburg and F. D. Bullock, New York.
93 An Obscure Case of Miliary Tuberculosis (Pulmonic Type) Diagnosticated by the Roentgen-Ray. G. Rosenbaum, Philadelphia.
94 Mortality from Venereal Diseases. H. A. Brown, Washington, D. C.
95 Side Lights on the Social Peril. M. Glasgow, New York.
96 *Foramitti's "Tubilization" Method of Nerve Suture. G. Torrance, Birmingham, Ala.
97 Rupture of the Intestine from a Blow on the Abdomen. H. A. Royster, Raleigh, N. C.
98 Amygdalotomy or Amygdalectomy. M. Lubman, New York.

84. **Disturbances of Mesenteric Vessels.**—Circulatory disturbances of the blood-supply of the small intestine that present themselves to the surgeon, are usually of such a character as ultimately to produce gangrene of the gut. Among these we have injury to the mesenteric vessels by trauma, constriction of the vessels by volvulus, intussusception, strangulated hernia, etc. The conditions present such a train of symptoms that diagnosis may frequently be made and surgical interference often check the evil before it is too late, and thus the parts be restored to normal, or what amounts to the same thing, a cure effected by resection. The principal symptoms are sudden pain of a marked degree, abdominal rigidity and tenderness, fever, either constipation of severity or stools mixed with blood. Hiccough is often present, and so is leukocytosis of high count. Another symptom, on which much stress may be laid, is a doughy sensation in that part of the abdomen overlying the swollen gut; this doughy area moves about as the position of the gut is changed. Later on, the gangrene produces a septic peritonitis with its marked symptoms. The treatment is obvious; the prognosis depends on the amount of gut to be resected and the condition of the patient. In lieu of a better name Collins has called this condition intestinal apoplexy. He reports three cases.

86. **Destruction of Surface and Cavity Neoplasms by Desiccation.**—The object of Clark's paper is to show a means whereby tissue may be destroyed by rapid depletion of its fluid element. The idea is to produce, control and sustain a degree of heat sufficient to cause rapid desiccation of the part to be treated, sterilizing and converting it into an inert mass. He says that a current from a static machine of large output with properly attuned accessories, when applied with correct technic and care is capable of producing a superficial or a deep destruction of tissue by desiccation, or rapid depletion of its fluid element, which breaks up and disintegrates the cells. It has sterilizing, deodorant, styptic, penetrating and stimulating properties. This specialized current has no particular affinity for abnormal tissue over the normal, but it is a simple matter to keep the destruction well within bounds on account of refinement of control. It is operative in all accessible lesions in which destruction is desirable, and works from without inward. Living tissue is destroyed by this means almost as readily as dead tissue (raw meat). The rapidity of action appears to be directly proportionate to the density of the tissue. Clark has tried the method on 317 lesions and is very enthusiastic over the results.

96. **Foramitti's "Tubilization" Method of Nerve Suture.**—Following a traumatic section of the musculo-spiral nerve, Torrance's patient developed wrist drop with the hand drawn toward the radial side; pronation and supination only slightly affected; the ring and little finger were flexed on the palm and the other fingers were partially flexed; had lost all power of extension of the thumb; complete loss of sensation in the thumb and index finger and extending up to the wrist. Six months after the injury the nerve was exposed and found to be severed just above where it divides into the radial and interosseous, so that the ends were not widely separated and were caught in the scar tissues of the wound; each end showed a bulb formation of the nerve and scar tissues; these were excised and the nerve terminals sutured together with fine catgut in an absorbable tube prepared from the artery of a cow after Foramitti's method, slightly modified; good apposition was obtained. The wound was closed without drainage and a cast was applied with the arm at right angles. When seen a month after the operation the wound was perfectly healed and the patient had regained sensation in the hand, except in a narrow strip across the thumb at the base

of the nail, and she could extend the fingers to a right angle with the palm.

She was lost sight of for more than a year, when she reported that the numbness in the thumb had disappeared in about nine months and that the arm and hand were perfectly normal at the end of a year.

Medical Fortnightly, St. Louis

May 25

99 *Treatment of Patients Desperately Ill in Consequence of Accident (Shock, Hemorrhage and Infection). C. E. Bowers, Wichita, Kan.
100 One Side of a True Analogy Largely Lost Sight of. E. E. Clark, Danville, Ill.
101 Tubercular-Phobia. C. Pope, Louisville, Ky.
102 Typho-Bacilliosis. W. F. Waugh, Chicago.
103 In the Twilight. C. E. Warren, North Easton, Mass.

99. Abstracted in THE JOURNAL, Nov. 5, 1910, p. 1676.

Medical Record, New York

June 10

104 *Stretching of the Pylorus in Benign Stenosis. M. Einhorn, New York.
105 *Pollution of Harbor Water Used in Free Floating Baths. L. R. Williams, New York.
106 *"Carriers" in Relation to the Spread of Diphtheria. E. C. Hill, U. S. Army.
107 *Acute Psychosis Due to Belladonna Poisoning. M. A. Starr, New York.
108 Possible Causes of Failure Following Use of Bacterial Vaccines and Antiserum. H. E. Plummer, New York.
109 Stokes-Adams Disease; Report of Cases. J. C. Johnston, McAlester, Okla.
110 *Neglected Phase of Prevention of Summer Gastro-Enteric Disease in Infants. Le G. Kerr, Brooklyn, N. Y.
111 Heart Displacement in Pulmonary Tuberculosis. H. Greeley, Brooklyn, N. Y.

104. Abstracted in THE JOURNAL, May 27, 1911, p. 1601.

105. **Pollution of Harbor Water.**—While bathing in floating baths and in other contaminated waters it has been shown that water is taken into the mouth. The casual bather, therefore, runs a risk of receiving typhoid bacilli into his alimentary canal by bathing and swimming, and the risk of the constant bather is increased. A thorough study of the floating baths of New York leads Williams to draw the following conclusions: There are a large number of people in the metropolitan district constantly ill of specific diseases. The discharges of many of these patients containing specific disease-causing bacteria are emptied undisinfected into the sewage. Some of these bacteria, notably the typhoid bacillus, may live for days in sewage and sea water. Other bacteria causing specific diseases may live in sewage and sea water, though less is known about them. There is danger in bathing in the harbor waters. The floating baths have but little cleansing value and the water is unwholesome for bathing purposes. They may be refreshing to some and give pleasure to thousands, some of whom learn to swim. Floating particles of sewage enter many of the baths even though they are situated 500 feet or more from sewer outlet. The quality of the water adjacent to the shores of Manhattan and Brooklyn in the East and Hudson Rivers and the Harlem River is such that it is unsuitable for bathing purposes even though it were possible for the baths to be so situated and protected that floating particles of sewage did not enter the floating baths. This water is constantly diminished in oxygen, contains large numbers of bacteria, among which are colon bacilli in 0.01 to 0.001 of a c.c. of water. While bathing in these waters it is hardly possible to prevent water from entering the mouth and nasal passages and also the mucous membrane of the eye, and bathing in such water is a constant source of infection.

106. **Spread of Diphtheria.**—It is held by Hill that carriers, missed cases and atypical and undiagnosed cases of diphtheria must be considered as of as much more importance in the spread of the disease than fomites. House disinfection and quarantining healthy as well as sick inmates of a household is an unscientific method of controlling epidemics if no attention is paid to carriers. A rational use of antitoxin, i. e., sufficient dosage at frequent intervals, will, undoubtedly, greatly reduce the present high death-rate from diphtheria.

107. **Acute Psychoses Due to Belladonna Poisoning.**—Two cases of belladonna poisoning are reported by Starr which did not present the usual symptoms but presented a state of mental excitement most unusual and interesting. He says that the sudden development of illusions, hallucinations and delusions in a previously healthy person should always awaken suspicion of a toxic psychosis.

110. **Prevention of Gastro-Enteric Disease in Infants.**—The time to commence treatment of the summer diarrheas of infants, according to Kerr, is in the late spring or at the latest the early summer. Gastro-enteric disease, as it is expressed in infants and young children, is not always an acute process. In fact, although it appears as an acute condition, it is uncommonly such, and careful history-taking will almost invariably reveal the fact that the acute process is one that is developed on a soil which has been long prepared for it. Thus the prevention of digestive disturbances is the largest factor in the limitation and prevention of acute gastro-enteric disease.

Therapeutic Gazette, Detroit, Mich.

May

112 Diagnosis of Facial Pains from Those of Tic-Douloureux and Their Treatment by Alcoholic Injection. T. H. Weisenburg, Philadelphia.
113 What Cases of Constipation Are Amenable to Surgical Treatment? J. G. Clark, Philadelphia.
114 Infantile Pyloric Stenosis and Infantile Spasmodic Pyloric Stenosis. A. L. Hertel, St. Louis.
115 Diagnosis and Treatment of Tuberculous Lesions in the Upper Respiratory Tract. G. B. Wood, Philadelphia.

Boston Medical and Surgical Journal

June 15

116 Obstetrics in General Practice. A. Worcester, Waltham, Mass.
117 *Hexamethylenamin as a Possible Preventive of Pneumococcus Empyema. F. C. Shattuck, Boston.
118 *"Fibrositis" as a Cause of Chronic Hypertrophic Spondylitis; A Heretofore Undescribed Sign in Intestinal Auto-Intoxication. N. S. Yawger, Philadelphia.
119 *Treatment of Gastric Hyperacidity with Hydrogen Peroxid. G. W. Hall, Boston.
120 A Case of Vertigo Cured by Treatment of the Eustachian Tube. E. M. Holmes, Boston.
121 A Case of Nerve-Deafness Due to the Toxemia of Diabetes. W. H. Merrill, Lawrence, Mass.
122 Lateral Deviations of the External Nose. A. Coolidge, Boston.
123 Plaster Casting from Life to Show External Deformities of the Nose Before and After Correction. I. D. Kerr, Boston.

117. **Hexamethylenamin and Pneumococcus Empyema.**—From March 1, 1910, to March 1, 1911, fifty-nine cases of lobar pneumonia were treated with hexamethylenamin in the medical wards of the Massachusetts Hospital. This number includes only cases in which the diagnosis seemed assured. The drug was given as soon as the diagnosis was made, and the dose was 10 gr. three times a day, continued until death or well into convalescence. In three cases of young children the dose was proportionately less. The duration of illness before the drug was given varied from one to sixteen days, averaging five and one-half days. The duration of the hexamethylenamin treatment averaged twelve days. Three of these cases developed empyema. During the same period, there were forty-six cases of lobar pneumonia treated without hexamethylenamin. Three or four of these were not given the drug because moribund when brought to the hospital, and in one the pneumonia was a terminal event in chronic nephritis. In general, however, the cases were of the same class as those comprising the hexamethylenamin series. There was no selection of cases for the treatment. Of this number only one developed empyema. In the preceding year, March, 1909, to 1910, of 142 cases of lobar pneumonia without hexamethylenamin, three developed empyema. Excepting in one doubtful case, no urinary disturbance could be attributed to the hexamethylenamin, although the average finding of albumin and casts was higher in the hexamethylenamin cases than in the others. Pericarditis, which complicated 4 or 5 per cent. of the non-hexamethylenamin cases in both years, was not observed in the hexamethylenamin series. The same is true of otitis media, which occurred in 3 to 4 per cent. of the cases not under the drug.

The mortality of cases in the hexamethylenamin series (20 per cent.) is a little lower than in the other series (25 per cent. in 1909 and 26 per cent. in 1910); but not counting the cases which did not receive hexamethylenamin because they were moribund, the mortality of the hexamethylenamin series would be as great or a little greater than that of the others.

Shattuck believes that his results are not encouraging to the hope that in hexamethylenamin we may have a preventive for empyema, one of the most frequent, and, from the point of view of the comfort of the patient, the most serious sequelæ of pneumonia. They suggest, however, that this drug may be a preventive of pericarditis and otitis media. Of course, it may be a mere coincidence that neither of these complications developed in the hexamethylenamin cases, but the contrast between the two series leads Shattuck to continue the use of the drug, and thus perhaps to arrive at more definite conclusions.

118. **Fibrositis and Chronic Hypertrophic Spondylitis.**—Having studied a considerable number of cases of chronic "rheumatic" myositis and having observed in these cases many instances in which the skin, fasciæ, fat and periosteum as well as muscles were involved, and also finding tenderness and stiffness quite commonly present about the spine in many persons in whom other parts were affected, it has seemed to Yawger that chronic hypertrophic spondylitis is often but the spinal localization of a very common general condition, and which, in a mild degree, is quite frequently present. In many instances these various manifestations appear to have a common cause, this being auto-intoxication of intestinal origin. Of course, Yawger says, it is important to distinguish between a stiff back due to adventitious osseous formations and that due to chronic muscular rheumatism, and this may be done with the administration of an anesthetic, when the latter condition yields readily, while the former remains unchanged. A skiagraph will also help to clear up the diagnosis.

119. **Gastric Hyperacidity.**—The results obtained by Hall in the treatment of thirty patients who complained of distress or pain, referred to the stomach with other symptoms of hyperacidity by means of hydrogen peroxid show that it diminishes the amount of hydrochloric acid in the stomach; that those patients with hyperchlorhydria get great or total relief from their symptoms; that there is a gain in weight; that it does not appear to benefit cases with active ulcer; and finally, that this method of treatment is a useful addition to the methods already in use in the treatment of hyperchlorhydria.

Annals of Otology, Rhinology and Laryngology, St. Louis

March

124 Therapeutic Value of Radium in Treatment of Diseases of the Upper Air Tract. W. Freudenthal, New York.
125 Examination and Treatment of the Nasopharynx and Eustachian Tube by Aid of the Nasopharyngoscope. E. M. Holmes, Boston.
126 Electric Nasopharyngoscope. F. P. Emerson, Boston.
127 A Case of Cerebellar Abscess Presenting Certain Features Suggestive of Labyrinthine Suppuration. P. D. Kerrison, New York.
128 Suppurative Otitis Media Treated with Suspensions of Lactic Acid Bacilli. W. H. Haskin, New York.
129 Pathologic Conditions of the Ear Resulting in Profound Impairment of Hearing. E. B. Dench, New York.
130 A New Method of Eliciting the Functional Ear Tests. E. P. Fowler, New York.
131 Sarcoma of the Nose and Nasopharynx. T. H. Farrell, Utica, N. Y.
132 Carcinoma of the Pinna and External Auditory Canal. H. A. Kiefer, Los Angeles.
133 Educating the Eye to Substitute for Deaf Ears. E. B. Nitchie, New York.
134 The Ideal Clinic in Laryngology. A. J. Huey, New York.
135 The Yankauer Operation in Chronic Middle Ear Suppurations. H. Hays, New York.
136 Pathogeneis of Otosclerosis. G. Ferreri, Rome.
137 Sinus Thrombosis with Special Reference to the Diagnostic Value of Blood-Cultures in Otitic Disease. S. Oppenheimer, New York.
138 Cases of Ear Suppuration Presenting Irregular Symptoms. E. B. Dench, New York.
139 A Case of Sinus Thrombosis, with Extensive Accumulation of Fluid Pus in the Sinus: Recovery After Resection of the Jugular Vein. R. L. Loughran, New York.
140 Mechanical Aids to Hearing. P. Fridenberg, New York.
141 Physiologic Vestibular Nystagmus. J. R. Fletcher, Chicago.
142 The Improved Technic of the Thiersch Graft Following the Radical Mastoid Operation. C. F. Welty, San Francisco.

Lancet-Clinic, Cincinnati

June 10

143 Cooperation, Inspection and Reorganization of Medical Colleges. J. U. Barnhill, Columbus, Ohio.
144 Acute Pericarditis with Effusion. C. A. Tribbet, Westboro, Ohio.

June 17

145 Enucleation of the Eye Under Local Anesthesia—Indications and Technic. D. T. Vail, Cincinnati.
146 Importance of Teaching Dermatology and Syphilology in the Medical Colleges. A. Ravogli, Cincinnati.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Clinical lectures, single case reports and trials of new drugs and artificial foods are omitted unless of exceptional general interest.

British Medical Journal, London

May 27

1 *Rational Empiricism and Scientific Medicine: The Boundaries Dividing Them. Sir D. Duckworth.
2 Food and Feeding. R. Saundby.
3 *Cancer, Credulity and Quackery. E. F. Bashford.
4 Bonesetting. H. Marsh.
5 *Quackery and Female Complaints. Sir J. Byers.
6 Skin Diseases and Cosmetics. G. Pernet.
7 Practice of Medicine and Surgery by Unqualified Persons. J. H. Taylor.
8 Quackery in Rural Districts. C. E. S. Flemming.
9 Unqualified Practice in East Anglia. E. G. Barnes.
10 Bonesetting and Treatment of Painful Joints. F. Romer and L. E. Creasy.

June 3

11 *Fractures of the Patella and Their Surgical Treatment. C. B. Lockwood.
12 *Bursal Swellings About the Knee-Joint. A. E. Barker.
13 Pharmacologic Effects of Strong Sulphur Water. D. Brown.
14 Balneologic Treatment of Disease. W. R. Gore.
15 Cottage Nurses for Rural Districts. H. Hick.
16 Transmission of Trypanosoma Lewisi by Rat-Flea (Ceratophylus Fasciatus). E. A. Minchin and J. D. Thomson.
17 Comparative Nutritive Value of White, Standard and Whole-Meal Bread. L. Hill and M. Flack.

1. **Rational Empiricism and Scientific Medicine.**—Rational empiricism together with slowly progressive scientific medicine, says Duckworth, are now being carried on by the best practitioners. In the immediate interests of the sick this must be so, and there can be no antagonism between them so long as the whole field of medicine is not covered by science. The boundaries which divide them are sufficiently clear to all well-educated members of the profession. It is as possible to be too empirical as it is to be too scientific in daily practice. Some therapeutic methods urged on an alleged scientific basis have ultimately proved to be unscientific, and of little or no value. In the meantime, Duckworth says, we need to be both more prudently empirical, and more on the alert to avail ourselves of such knowledge as comes to us with the imprimatur of honesty and exact laboratory research. Such research must, however, be carried on with close and prolonged clinical cooperation. In that way only true progress lies. The task is, indeed, a difficult one, and the outlook for all engaged in it appears likely to become more burdensome for each generation. Such seekers after truth must not expect much sympathy or support from the public, which looks for results quickly wrested from Nature, and is apt to be impatient with slow and persevering research. They know, however, that the true philosopher, who makes his mark for all time, reserves his results till he has covered the whole field of his research, and that he is the last man to seek untimely and sensational publicity for them.

3. **Cancer, Credulity, and Quackery.**—A few of the so-called "cancer cures" investigated by the Imperial Cancer Research Fund are spoken of by Bashford, also the reasons for the existence of so much credulity on the part of the public.

5. **Quackery and Female Complaints.**—The suppression of quackery, Byers believes, may be brought about in three ways: (1) By doing everything to advance the progress of medical science and to improve the art of healing; (2) by educating the public as to the folly of quack nostrums, particularly in the direction of the exposure of "secret remedies," by scientific analysis as to what they contain and what they cost, as is being so admirably carried out by the British Medical Association; and (3) by demanding that there should be legislation on the subject which might follow the lines indicated by the executive committee of the Association of County Councils in Scotland, who have recommended their association to adopt a resolution to the effect that the Sale of Food and Drugs Acts should be amended and extended so as to provide: (1) That for medicines which are supplied otherwise than on medical, dental or veterinarian prescriptions, no condition of sale short of the publication on each packet of medicine of the name and quantity of each of its constituents should be permitted. (2) That the label should be made to constitute a warranty; and that a false description, whether on the label or main advertisement, should be made an offense. (3) That the provisions of the Sale of Food and Drugs Acts should be applied to proprietary medicines.

11. **Fractures of Patella and Surgical Treatment.**—Lockwood strongly favors treating all fractures of the patella by an open operation. It gives a far better result in a far shorter time. The advantages gained far outweigh the risks.

12. **Bursal Swellings About Knee-Joint.**—Barker not only discusses the usual enlargements of bursal cavities about the knee, but also suggests that in some obscure conditions in this region an explanation may be found in enlargements of synovial tracts which are sometimes forgotten. In the case of enlargement of some of them he believes that they are the origin of those large cystic swellings which have been erroneously believed to be due to hernial protrusions of the synovial membrane of the knee-joint. As to treatment, we are safest when we regard them as rudimentary joints, and deal with them as such. And as it is now recognized that joints may be dealt with freely by operation with a good prospect of the preservation of their functions, so may these bursal sacs.

Lancet, London

June 3

18 *Progressive Spinal Muscular Atrophies of Infants (Werdnig-Hoffmann). F. E. Batten.
19 The Medico-Chirurgical Transactions a Hundred Years Ago. J. M. Bruce.
20 Position of Present Reform Movement in Anesthetics. F. W. Hewitt.
21 *"Förster's Operation" of Posterior Root Section for Treatment of Spasticity (Rhizotomy). O. May.
22 Successful Removal of a Sarcoma from Head of the Pancreas. J. Sherren.
23 *Referred Penile Pain in Intussusception. G. E. Waugh.
24 Chronic Pancreatitis, Diagnosis and Treatment. P. J. Cammidge.
25 Gangrenous Pancreatitis; Operation; Recovery. G. A. Wright and E. L. Luckman.
26 Tobacco Dyspnea. J. D. Reckitt.
27 Burns of Anterior Aspect of the Chest and Neck, with Part of Lateral and Posterior Aspects. E. F. Travers and D. F. Maunsell.

18. **Progressive Spinal Muscular Atrophies of Infants.**—The case described by Batten illustrates a type of progressive paralysis beginning in a child below the age of 12 months, affecting, in the first place, the trunk and proximal muscles, gradually spreading to those more distally situated, affecting the intercostals but sparing the diaphragm. The intelligence, sensation, and the visceral functions remain unaffected. Pathologic examination of other cases shows that this progressive paralysis is due to a change in the cells of the anterior horn caused by some toxin or condition the nature of which is at present unknown.

21. **"Forster's Operation" of Posterior Root Section for Treatment of Spasticity.**—In May's case, the operation yielded the most satisfactory results. The spasticity was of congenital origin. The patient was 5 years old. His condition before operation was as follows: By the exercise of considerable force the leg could be almost fully extended, but would spring back immediately it was released. If the heel of one foot was raised quickly from the bed the other promptly followed it. If done very gradually the other heel was raised when the first was about 10 inches from the bed. The maximum separation possible of the knees was 7 inches and of the ankles 15 inches. If one leg was held down the other could not be raised more than 12 inches (from the bed to the heel). The maximum voluntary separation of the heels was about 6 inches, and this could not be sustained, the legs returning quickly to the crossed position. The legs could not be moved independently at all; efforts to raise one leg caused movements of all the limbs and often of the head as well. All the tendon jerks—knee, ankle, adductor, etc.—were tremendously exaggerated; ankle-clonus was not obtained, being prevented by the strong contracture of the plantar flexors of the ankle. Even light pressure over the adductor tubercle of the thigh caused a spasmodic movement of the whole frame—limbs and trunks. The plantar reflexes were of the extensor type, and Oppenheim's reflex was easily obtainable. No impairment of sensation could be detected. The second sacral and fifth, third and second lumbar posterior roots on each side were successively resected. Three weeks after operation, forcible extension of the knee seemed rather painful; otherwise there was no evidence of pain. The legs could be widely abducted, until the ankles were nearly 30 inches apart. There was still, however, some degree of spasticity of the adductors and hamstrings; the calf muscles were free, so that the foot could be fully dorsi-flexed. The reflexes were as previously noted. The child had lost the marked spasm previously elicitable by pressure over the insertion of the adductor magnus. Each leg could be fully flexed at the hip without producing any appreciable movement of the other leg.

23. **Referred Penile Pain in Intussusception.**—The occurrence of paroxysmal attacks of pain referred to the end of the penis and suprapubic region in association with an intussusception appears not to have been recorded up to the present time. Its association in cases with a definite abnormal type of mesenteric formation, and the fact that in one case this primitive persistence of mesenteries was diagnosed before the operation and confirmed by the operation, are additional reasons why Waugh calls attention to it. Lastly, some unusual features of intussusception formation appear to depend on the presence of these mesenteries, and when their presence can be recognized beforehand by reason of this referred pain a departure from the usual traditional treatment of immediate operation can be justified with advantage to the patient. The clinical signs and symptoms common to these cases briefly were these: Pain in the abdomen and vomiting at intervals, were present for about a week before admission to hospital. The pain was paroxysmal in nature, was sufficiently intense to make the patient cry out loudly and clutch the end of the penis. The penis and suprapubic region were lacerated by the fingernails. In all the cases the pain had been present for two or three days before the vomiting began. The abdomen was soft, not distended, and moving freely. A tumor of the usual character of an intussusception was present in the left iliac fossa and easily palpable per rectum. Small quantities of feces were passed at intervals, with only an occasional slight trace of mucus, and on one occasion a tinge of blood was present. In these three cases development had been arrested at the stage of rotation, so that no fusion of the retrocolic folds of peritoneum had occurred. That is to say, both the ascending and descending colons hung freely from the posterior abdominal wall, with a fold of peritoneum nearly one inch in depth behind them, forming an ascending and descending mesocolon, while the mesocolon of the transverse portion of the large gut had not fused with the layers of the great omentum, so that part of the intestine lay in the abdominal cavity at a level just below the transumbilical plane. Further evidence of a primitive stage of development was the presence of a large appendix fully three inches in length, reaching up to the under surface of the right lobe of the liver, with an extensive and well-vascularized meso-appendix in all the cases, while in addition, in one of them a Meckel's diverticulum was present and in another a large congenital hernial sac in the left inguinal canal.

Medical Press and Circular, London

May 24

28 Endometritis. G. E. Herman.
29 Cases Illustrating the Origin of Hysterical and Pseudo-Hysterical Symptoms. T. A. Williams.
30 Errors of Diagnosis in Supposed Cases of Appendicitis. G. P. Newbold.
31 Hand Atrophies. C. M. H. Howell.
32 Treatment of Scar Tissue. W. K. Sibley.

May 31

33 Displacements of the Uterus and Pelvic Floor. J. S. Fairbairn.
34 *Absence of the Fallopian Tubes, with Recurrent Peritonitis; Spencer's Operation. E. A. Chill.
35 *Malformations of the Uterus, Tubes and Ovaries of Clinical Interest. A. Doran.
36 Injection of Paraffin in Depressed Scars, Furrows and Other Cosmetic Defects. D. Walsh.
37 A Case of Duodenal Ulcer. O. Smith.

34. **Absence of Fallopian Tubes.**—In the case cited by Chill there was absence of the Fallopian tubes and of menstruation, associated with monthly recurring attacks of peritonitis. A woman, aged 31, married three years, never had any menstrual flow. No blood or blood-stained fluid had ever been passed. At the age of 14, attacks of pelvic pains began and recurred monthly, lasting three to seven days, during which there might be a little whitish-yellow discharge, but never enough to require a diaper. These attacks became more and more severe, affecting the lower half of the abdomen, beginning on one side and spreading to the other, but always worse on the left side. This was accompanied by nausea, headache and sweat-

ing. She had been under treatment without benefit. These attacks of recurrent peritonitis rendered the patient weak and thin, but beyond this, everything, including the breasts, pubic hair, external genitals, vagina and uterus appeared normal. There was tenderness on pressure in both iliac regions and rigidity over the lower abdomen. *Per vaginam*, a tender swelling could be felt on each side behind and external to the uterus, more marked on the left side. The body of the uterus was quite normal; in the place of each cornu was a pea-like knob. There was no sign of the main portion of the Fallopian tube on either side, but the round ligament was well defined, and there was nothing else abnormal about the inner part of the broad ligament. Each ovary was enclosed in a pouch formed by peritoneal adhesions; the opening of the pouch into the general peritoneal cavity was directed backwards; the peritoneal surface of the ovaries projected into the interior of the pouches. This surface of the ovary appeared normal, and on pricking one of the follicles fluid spurted out. Chill did not observe any sign of a corpus luteum of menstruation, nor any remains of blood-clot or pigment whatever. In the wall of the sac where it was continuous with the broad ligament there appeared to be traces of the fimbriæ of the Fallopian tube. A uterine sound was passed quite easily and to the normal distance. But the lumen of the uterus did not extend into the pea-like knobs previously noted. On the left side the knob contained a small dermoid cyst enclosing sebaceous material but no hairs. On the right the knob was a mass of fibrous tissue. A drainage tube was passed downward from the uterine cavity through the cervix, and the orifices of the two ovarian pouches were brought over the uterus and sutured so as to establish a continuity with the uterine cavity. The patient has returned frequently for examination, is in very good health and has had no further attacks nor abdominal disturbance.

35. **Malformations of Uterus, Tubes and Ovaries.**—Four cases are reported by Doran: (1) Arrested development of the upper part of the female genital tract; (2) hermaphroditism detected in operations for hernia; (3) distention of the otherwise well-developed uterus and Fallopian tubes, with menstrual blood; (4) bifid and unicorn uterus in parous subjects.

Tropical Medicine and Hygiene, London

May 15

38 Curative Influence of Roentgen Rays in Malaria. H. D. McCulloch.
39 Cultural Characters of the Fungi of *Tinea Imbricata*. A. Castellani.

Annals of Tropical Medicine and Parasitology, Liverpool

April

40 Further Experimental Researches on the Etiology of Endemic Goiter. R. McCarrison.
41 Non-Ulcerating Oriental Sore: The Cultural Characteristics of the Parasite as Compared with a New Similar Parasite in Erthesina Bullo (Thumb), a Pentatomid Bug. R. M. Carter.
42 Infantile Leishmaniasis (Marda Tal Biccia) in Malta. A. Critien.
43 *Production, Life and Death of Crescents in Malignant Tertian Malaria, in Treated and Untreated Cases. D. Thomson.
44 *The Leukocytes in Malarial Fever: Method of Diagnosing Malaria Long After It Is Apparently Cured. D. Thomson.
45 Yellow Fever in the Black Race and Its Bearing on the Question of the Endemicity of Yellow Fever in West Africa. Sir R. Boyce.
46 The Ameba Parasitic in the Human Intestine, with Remarks on the Life-Cycle of Entameba Coli in Cultures. H. B. Fantham.
47 Observations on the Tsetse-Fly, Described as Glossina Grossa. R. Newstead.
48 The Correlation Between Trypanosomes, Leukocytes, Coagulation Time, Hemoglobin and Specific Gravity of Blood. V. T. Korke.

43. **Production, Life and Death of Crescents in Malignant Tertian Malaria.**—Thomson believes that crescents are produced from the ordinary asexual spores of *P. falciparum*, due to a development of immunity towards the latter. They develop somewhere in the internal organs and then appear suddenly in the peripheral blood. The period required for their development is about ten days. Crescents do not generally live more than a few days in the peripheral blood. Crescents may be present in the peripheral blood during periods as long as eight weeks, not because the individual crescents survive for that time, but because their numbers are constantly replenished from surviving asexual forms. Fresh broods of crescents come into the circulating blood daily, or every other day, or irregularly, according as the asexual sporulations occurring ten days before were quotidian, tertian, or irregular. Quinin has no direct destructive action on crescents, either during their development or afterward, but it destroys the asexual source of supply. Quinin reduces the crescents to numbers less than one per c.mm. of blood within three weeks, provided it be given in daily doses of twenty to thirty grains. Quinin in small doses tends to increase crescent production (?) by favoring the development of immunity to the asexual parasites. Methylene-blue in doses of 12 gr. daily reduces the number of crescents, and would seem to have some direct destructive action on them.

44. **Leukocytes in Malarial Fever.**—During active malaria the number of leukocytes in the peripheral blood is decreased. During quiescent malaria, and in cases apparently cured by treatment, the leukocytes in the peripheral blood are much increased. During the rigor and temperature in malaria, the mononuclear leukocyte percentage (more especially that of the large mononucleated variety) is low. With the fall of temperature, however, the mononuclear percentage rises very high, sometimes even to 90 per cent. of the total leukocytes. This fluctuation in the percentage of total mononuclear leukocytes occurs also long after continuous quinin treatment, and is observed for months and even years (?) after the last attack of fever. In these apparently cured cases of malaria, the mononuclear percentage is lowest at the time of the day at which the rigor and fever occurred during the previous active malaria; and, moreover, at this time there also occurs a very marked leukocytosis, which continues for only a few hours. The leukocytes often reach numbers as great as 30,000 to 50,000 per c.mm. of blood. On one occasion, noted by Thomson, they were as numerous as 125,000 per c.mm. Two hours later they had fallen to 22,000 per c.mm., and in eight more hours there were only 6,000 per c.mm. This case showed a regular daily periodic variation in the number of leukocytes, averaging from about 6,000 per c.mm. to 50,000 per c.mm. The height of the rise always occurred about noon. This was the time at which the rigor and fever, which was quotidian, was wont to occur previously. This post-malarial leukocyte phenomenon occurred always without exception in the forty cases examined, and would therefore seem to be an infallible sign of previous malaria, as, so far, it has not been observed in any other disease. It would appear, says Thomson, that large numbers of malarial parasites on sporulating cause leukopenia, while a very small number on sporulating cause a leukocytosis.

Journal of Laryngology, Rhinology and Otology, London

May

49 Fibrolysin in Otology. M. Yearsley.
50 The Visual Fields in Sphenoid and Ethmoid Sinusitis. G. F. C. Wallis.
51 Case of Thrombosis of the Lateral Sinus Exhibiting Symptoms of Cerebellar Abscess; Operation; Recovery. J. W. Wood.

Australian Medical Journal, Melbourne

April

52 *Etiology of Acute Rheumatism. A. V. M. Henderson.
53 Treatment of Cardiac Affections of Acute Rheumatism. H. H. Turnbull.
54 *Manifestations of Rheumatism in Children. F. H. Cole.
55 Relationship of Botany to Medicine. A. J. Ewart.
56 *Functional Murmurs in Children. R. M. Downes.
57 Ten Cases of Poisoning by Castor-Oil Seed. W. A. Wood.
58 Case of Sudden Death from Pulmonary Infarction. W. H. Brown.

52. **Etiology of Acute Rheumatism.**—Anderson's paper is a summary of the present stage of our knowledge of the etiology of acute rheumatism and other diseases apparently related to it. He believes that we may, at present, regard rheumatic fever as an acute infectious disease, the predisposing causes of which are to some extent known; and that its exciting cause is a germ, probably a diplococcus or streptococcus, and possibly the organism investigated by Poynton and Paine.

54. **Rheumatism in Children.**—Cole believes that in nearly all cases, the rheumatic heart in children comes to stay and to destroy, partly, no doubt, because the difficulties of management and treatment over long periods are almost insuperable.

56. **Functional Murmurs in Children.**—Downes regards it as advisable to bear well in mind, in regard to the question of treatment and prognosis, the frequency with which marked murmurs are present in children even with some signs of enlargement of the heart suggestive of congenital heart disease, these signs rapidly vanishing on change of posture, or on improvement of the general health. In addition, he says, the fact of the normal greater intensity of the pulmonary second sound in children has to be remembered in making a diagnosis of organic disease of the heart.

Annales des Maladies des Org. Génito-Urinaires, Paris

May 1, XXIX, No. 9, pp. 769-864

59 Pyelotomy for Removal of Renal Calculi; Six Cases. P. Bazy.
60 Complete Retention of Urine in Ulcerative Cystitis in Woman of 68. G. Gross and L. Heully.
61 Anuria Due to Presence of Calculi; Three Cases, One Fatal. Kousnetzki.

Annales de Médecine et Chirurgie Infantiles, Paris

May 1, XV, No. 9, pp. 273-304

62 The Appetite in Children. E. Périer and Gaujoux.

May 15, No. 10, pp. 305-336

63 Vomiting in Children. E. Périer and Gaujoux.
64 Management of Day Nurseries. (Le fonctionnement d'une crèche.) H. Boquet.

Archives des Maladies du Cœur, Etc., Paris

May, IV, No. 5, pp. 273-336

65 The Extrasystole as a Symptom and in Prognosis. M. Leconte.
66 Case of Adams-Stokes Syndrome Without Heart-Block. (Syndrome de Stokes-Adams, sans lésion du faisceau de His et sans blocage complet, dans un cas de péri-aortite avec médiastinite fibreuse dans la région du plexus cardiaque.) J. Mollard, A. Dumas and J. Rebattu.
67 Experimental Myeloid Reaction. R. Herts.

Lyon Médical, Lyons

April 30, CXVI, No. 18, pp. 777-820

68 Acute Colitis with Necrosis: Two Cases. M. Ducand.

May 7, No. 19, pp. 821-872

69 Acute Encephalitis in Course of Pneumonia. J. Mollard and A. Dufourt.

May 14, No. 20, pp. 873-916

70 The Roots in the Nervous System. (Les Racines du système nerveux.) J. P. Morat.

Presse Médicale, Paris

May 24, XIX, No. 41, pp. 425-432

71 The Domain of Psychiatry. J. Dejerine.
72 *Should High Blood-Pressure Always Be Combated? A. Martinet.
73 Hay Asthma. (Asthme des foins.) P. Maurel.

May 27, No. 42, pp. 433-444

74 Clinical Examination of the Duodenum. R. Gaultier.
75 Paralytic Zona of the Cerebral Nerves and the Theory of Acute Posterior Poliomyelitis. H. Claude and H. Schaeffer.
76 Ankylostomiasis. H. Benoit-Bazille.

72. **Should Hypertension Always be Combated?**—Martinet concludes from his study of this question that when the systolic pressure drops while the diastolic pressure rises, this is a sign of weakening of the myocardium. On the other hand, when the systolic pressure drops and the diastolic drops with it, this is a sign of true primary hypertension in the artery; it is generally a favorable sign. In every case of hypertension there is a lower limit to the pressure in the artery, below which the pressure cannot be reduced without injury to the myocardium.

Revue de Gynécologie, Paris

March, XVI, No. 3, pp. 209-344

77 *Hermaphrodism. (Hermaphrodisme. Ses variétés et ses conséquences pour la pratique médicale.) T. Tuffier and A. Lapoint. (Neuf cas personnels de pseudo-hermaphrodisme.) S. Pozzi.

April, No. 4, pp. 345-440

78 Ovarian Cytotoxins. S. D. Chiaje.
79 Complex Case of Exstrophy of the Bladder. O. Cohrs.

77. **Hermaphrodism.**—This whole issue of the *Revue* is devoted to this subject, Tuffier and Lapoint reporting a case and comparing it with others on record. When dubious as to the sex of an infant they say that the physician had better inform the family of his doubts but at the same time advise to have the child brought up as a boy, as 75 per cent. of all hermaphrodites turn out to be of this sex, and, in the other event, it is easier to make the change than if a boy has been brought up as a girl. An incision in the inguinal region is a simple matter to confirm the sex, especially as a further operation generally follows. Exploratory laparotomy is justifiable in some cases. Kolisko did this on a 2-year-old child and determined the presence of normal internal female organs, but it might be better to wait until the age of 5. The medicolegal and surgical aspects are discussed by Pozzi, with a profusely illustrated description of nine cases of pseudohermaphrodism.

Revue de Médecine, Paris

April, XXXI, No. 4, pp. 265-344

80 *Recurring Erythema in the Tuberculous. E. Devic and C. Gardère.
81 *Tuberculous Rheumatism. L. Tommasi.
82 Experimental Research on Antiglycosuria Serums. L. Castriota.
83 Dementia Præcox. Pascal.
84 Pleurisy in Diabetes. Braillon.

May, No. 5, pp. 345-432

85 *Banti's Disease. W. Oettinger and P. L. Marie.
86 Potato in Diet of Diabetics. (Valeur de la pomme de terre comme aliment chez les diabétiques.) F. Rathéry.
87 Pericardial Friction in Tuberculous Pericarditis. E. Devic and C. Gardère.
88 Results of Experimental Inoculation of Meningococcus. R. Debré.
89 Actinomycosis of Base of Skull and Meninges. J. Belkowski.
90 Prevalence of Diabetes. R. Lépine.

80. **Recurring Erythema in the Tuberculous.**—In the case reported the woman had five recurring attacks of an eruption resembling that of scarlet fever, succumbing in the last attack which was of a hemorrhagic nature with femoral thrombosis and gangrene. Some of the attacks seemed to develop spontaneously while others followed the administration of antipyrin, etc. The erythema in such cases is evidently a manifestation of an idiosyncrasy or anaphylaxis. In the present case the first eruptive attack was diagnosed as measles, the second and third as scarlet fever; the latter was finally excluded by the lack of severe sore throat and of contagion of others and by the early desquamation.

81. **Tuberculous Rheumatism.**—Tommasi found a distinct history of some supposedly rheumatic joint trouble in 23 per cent. of his last hundred tuberculous patients. In 20 per cent. of the twenty-three cases the joint trouble had just preceded a hemoptysis or other manifestation of the tuberculosis. He gives the details of three cases in which the tuberculous nature of the joint trouble was very probable. One was a young girl with healed tuberculous lesions in the lung who had had pains in the joints at night for a month. They were severe but there were no signs of congestion or swelling in the joints affected and the fever was too slight for ordinary articular rheumatism. Necropsy showed conditions in the joints like those Poncet has described as typical of chronic tuberculous rheumatism. Death was due to intercurrent streptococcus septicemia. The tuberculin reactions had been negative during life. The second patient was a woman of 64 and all the large joints became painful and swelled but without redness or local heat. She died of intercurrent pneumonia three months later, and the necropsy findings were also typical of tuberculous rheumatism; the diffuse tuberculous fibrous processes in the lungs and a focus of osteomyelitis also testified to the tuberculous nature of the rheumatism. In all three cases salicylic medication did harm rather than good, and the local intolerance of heat was also striking. The importance of differentiation of the tuberculous rheumatism is due mostly to the necessity for treatment as for tuberculosis rather than for rheumatism, as the measures indicated for the latter do direct harm in the former. In the third case one joint was generally affected at a time for a few weeks and then another, the clinical picture being more of the nature of a serofibrinous synovitis with effusion.

85. **Banti's Disease.**—The patient in the case reported was a previously healthy young man whose spleen gradually enlarged in the course of three or four months. There were no other symptoms except a slight tendency to jaundice and on seven occasions vomiting of blood or melena. Splenectomy was done to put an end to the hemorrhages but the patient died in a postoperative hemorrhage. Necropsy showed lesions in the spleen, liver and splenic vein. The possibility of these is the gravest danger in operative treatment of Banti's disease. The mortality is 50 per cent. to date, but only 12.5 per cent. in

the cases in which the operation was done before the disease was extremely far advanced.

Semaine Médicale, Paris

May 24, XXI, No. 21, pp. 241-252

91 *Chronic Intestinal Stasis. F. Lejars..

May 31, No. 22, pp. 253-264

92 *Diffuse Phlegmons with Slow Course and Their Treatment. F. Moty.

91. **Chronic Intestinal Stasis.**—Lejars reviews a long array of articles in international literature on chronic constipation and intestinal obstruction from kinks and adhesions. The various operative measures that have been extolled have not obtained much credit, he says, in their home countries and there is still a broad field for research on the causes and accidents of intestinal stasis and their prevention. When medical measures fail, surgical should be applied in the appropriate cases before irreparable harm has been done, but the question as to the best mode of intervention is still open to discussion.

92. **Treatment of Diffuse Phlegmon with Long Course.**—Moty warns that extensive incisions may do harm in diffuse phlegmons, especially of the chest wall. He reports two cases in detail; his first patient was a young soldier and after a long period of extreme weariness and indisposition to exertion the pectoralis major was found protruding from a phlegmon below. In two days the swelling had extended in all directions and an erythema developed on the chest wall, sparing the phlegmon region proper. Several punctures were made but no pus could be discovered, until finally a little secretion drained away through a wick inserted in the last puncture hole. By the end of six weeks the patient was practically cured although very thin. Moty encountered a second case of this same deep, diffuse, erysipelatous, almost chronic phlegmon, also in a young soldier, and Galine has reported a similar case with a fatal outcome after extensive incisions. Moty ascribes his success with his two patients to his cautious conservative treatment, refraining from injuring the tissues, saying that this class of phlegmons displays little tendency to gangrene, and the purulent foci are small and long in developing. They are manifestly due to some general or generalized cause, as is shown by the long preceding malaise, and the small pus foci are gradually absorbed. Nature heals by a kind of autoserotherapy, the physician aiding with constitutional treatment, quinin, arsenic and tonics, but refraining from overactive local measures. What is the use of incising here and there to give issue merely to a little blood, with no effect on the general condition? It is far wiser, he says, to wait and merely puncture when the small circumscribed foci are revealed by fluctuation. They are the expression of a local reaction to the general affection and the natural defensive process should not be hindered by injuring the tissues from without in the useless search for pus. Moty does not go quite so far as Georgiades, of Athens, however. The latter now refrains even from puncture. He has encountered thirty-six cases of diffuse phlegmon in children, and reports that none died of the twenty-seven treated merely by applying a protecting and absorbent bandage, while six died of the nine who were treated by incisions.

Beiträge zur Klinik der Tuberkulose, Würzburg

XIX, No. 3, pp. 431-507. Last indexed June 3, p. 1690

93 Frequency, Importance and Specific Diagnosis of Bovine Tuberculosis. (Rindertuberkulose.) M. Klimmer.
94 The Air in Pneumothorax. (Untersuchungen über Pneumothoraxluft.) F. Tobiesen.
95 Necropsy Findings in Lung Immobilized by Induced Pneumothorax. (Zur pathologischen Anatomie des künstlichen Pneumothorax.) E. Kistler.
96 *Children in Contact with Tuberculosis. (Das Kind im tuberkulösen Milieu.) R. Pollak.
97 Specific Endotin Treatment of Tuberculosis. I. Gabrilowitsch.

96. **The Child in a Tuberculous Environment.**—Pollak has been systematically examining conditions in the families with tuberculous infants, and has found it possible to trace the tuberculosis to its source in every such case. He has also applied the tuberculin test to 285 chilldren from 6 months to 14 years old who lived in contact with some tuberculous individual, and only six of the children failed to give a positive reaction to the tuberculin. Analysis of this material and of his experience outside has demonstrated, he asserts, that a great difference is evident between the children who were exposed to tuberculosis during infancy and up to the age of 4, and those who were not exposed to this infection until after the age of 4. While both give a positive tuberculin reaction, yet there are seldom manifest symptoms of tuberculosis in the children not infected until after the age of 4, and the infection seems to remain latent in them. On the other hand, the children infected before the age of 4 generally develop symptoms and grow up with the phthisical habitus. The tuberculous manifestations of older children may generally be regarded as the relapse of infection acquired during early childhood. When older children bear infection with tubercle bacilli without apparent harm, their systems must have gradually become proof against the tubercle bacilli. The experiences related emphasize anew the paramount importance of protecting children under 4 from infection with tuberculosis.

Berliner klinische Wochenschrift

May 22, XLVIII, No. 21, pp. 925-972

98 *Indications for Surgical Treatment of Gastric Ulcer and Its Consequences. (Magengeschwür.) L. Kuttner.
99 Radiology of the Stomach. (Geben uns die in der Radiologie zur Verwendung kommenden Metallsalze ein falsches Bild von Form und Grösse des Magens?) A. Hasse.
100 *Technic of Transfusion. W. Schultz.
101 Acute Benzol Poisoning. E. Buchmann.
102 Familial Inherited Eosinophilia. D. Klinkert.
103 *Bilateral Intrathoracic Vagotomy. E. Unger, M. Bettmann and S. Rubaschow.
104 Subcutaneous Injection of Tuberculin for Diagnosis in Animal Experiments. M. Jacoby and N. Meyer.
105 Growth Changes Suggesting Mutation in Cholera Germs. O. Weltmann.

98. **Gastric Ulcer.**—Kuttner discusses the indications for operative treatment and the final outcome in cases of gastric ulcer. He has encountered cases in which cancer developed in the floor of a round gastric ulcer and also cases in which a carcinoma developed in the vicinity of an ulcer and he has also witnessed the transformation of a benign pyloric stenosis into malignant disease. At the same time, he does not think that these occurrences are frequent. The greatest predisposition for cancerous degeneration is afforded by old ulcers and those in the prepyloric region. The ulcer developing cancer may show no symptoms of cancer and even with direct inspection, it may be impossible to distinguish between simple ulcer and cancer when only scraps of the tumor are examined. In Kuttner's thirty cases of resection on account of callous ulcer the microscope revealed cancer in over 43 per cent. These facts and the great benefit liable to be derived from an operation with simple chronic ulcer and benign pyloric stenosis have convinced Kuttner that in dubious cases and when there is the slightest suspicion of cancer, resection should be advocated. He regards it as the duty of the internist to appreciate the limits of his skill and the necessity for calling in the surgeon when this promises better results than internal treatment alone. Surgery is winning its best laurels in the field of gastric ulcer, but far better results will be attained, he declares, when all realize that the operation must be supplemented by a course of ulcer dieting. It is a great temptation to let the patient eat at will after the operation, but this avenges itself and sooner or later the patient returns with recurring ulcer or some dangerous complication, all of which might have been avoided by proper internist care after the operation. Not only before but during and after the operation, surgeon and internist must work together. He does not consider operative intervention except in the cases of gastric ulcer refractory to all internal measures and which by their persisting or continually recurring pains and vomiting permanently distress and debilitate the patient. Repeated ulcer courses are especially justified when there are long intervals in which the patient is free from disturbances.

100. **Transfusion of Blood.**—Schultz writes from Grawitz' service to describe the fine results obtained with transfusion from man to man after the blood has been tested for agglutinins and hemolysins with negative findings. By this precaution, it has been possible to eliminate the symptoms, such as collapse, chills, hemoglobinuria and edema, which formerly were common. At the same time, as is shown by a recent case described in detail, there must be some other biologic differ-

ences between the blood of the two persons which are as yet unknown but which may cause fever and malaise under certain circumstances. In the case reported, aside from the transient disturbance, great benefit was derived from the transfusion of 380 c.c. of defibrinated blood. In three days the red corpuscles had increased from 713,000 to 1,240,000.

103. **Bilateral Vagotomy.**—The research described was done with the Meltzer tracheal insufflation method for maintaining the pressure in the lungs and administering ether when the thorax was opened. Experiments on sixteen dogs showed, the writers say, that the Meltzer technic does not injure the lungs or heart and that severing the vagus close above the diaphragm has no injurious consequences for the functioning of the lungs and heart, but the stomach musculature becomes paralyzed and the contents are not moved along. If the stomach was full just before the operation and more food was taken afterward, the mass remained in the stomach and acute dilatation followed and ulceration was almost inevitable. If the stomach was empty before the operation and the dogs were given merely fluid food for eight or ten days afterward, the paresis of the stomach subsided and the dogs showed no injurious consequences from the operation. There was no vomiting on the part of the dogs, probably because the vagus was severed so low that the nerve fibers innervating the lower part of the esophagus were not divided.

Deutsches Archiv für klinische Medizin, Leipsic

CII, Nos. 5-6, pp. 457-624. Last indexed June 3, p. 1692

106 *Hitherto Undescribed Properties of the Urine. (Neue Eigenschaften des Harnes bei Gesunden und Kranken.) H. Pribram.
107 Pepsin in Urine Has No Diagnostic Importance with Gastric Cancer. (Harnpepsin bei Magencarcinom.) R. Bieling.
108 Localization of Atherosclerotic Processes in the Peripheral Arteries. S. Oberndorfer.
109 Metabolism of Salt and Kidney Functioning. (Experimentelle Untersuchungen über Kochsalzwechsel und Nierenfunktion.) H. v. Hoesslin and T. Kashiwado.
110 Congenital Pulmonary Stenosis and Secondary Changes in Blood. F. P. Weber and G. Dorner.
111 Study of Second Heart Sound. R. Wiesel.
112 Connections Between Nucleus and Plasma in Rudimentary Red Blood Corpuscles and Their Relation to the Hemoglobin. (Ueber Verbindungen zwischen Kern und Cytoplasma bei Erythroblasten und deren Beziehungen zum Hämoglobin.) W. Knoll.
113 *Independence of Peripheral Blood-Vessel System and Its Relations with the Central System. (Ueber die Selbständigkeit der Peripherie des Kreislaufes und ihre Beziehungen zum zentralen System.) K. Hasebroek.
114 Mercuric Cyanid Test for Sugar Content of Blood. (Neue Methode der Bestimmung des Blutzuckergehaltes.) H. Tachau.
115 Poisoning with Ammonium Sulphocyanid. (Vergiftung mit Rhodanammon.) O. Adler.
116 The Arneth Eosinophil Blood Picture. O. Roth.
117 *Diabetes and Cancer in the Pancreas. (Ueber Zuckerkrankheit und Krebs in der Bauchspeicheldrüse.) K. A. Heiberg.

Supplement.

118 General Index, Vols. I-C.

106. **Some New Properties of Urine.**—Pribram reports clinical, chemical and serologic research on the urine which has demonstrated, he says, that the urine injected into an animal induces the production of hemolysins, precipitins and complement-binding antibodies in the animal's serum. Precipitation occurs more intensely with normal urine than with urine containing albumin, while the complement-binding property is most marked with the latter. He discusses which elements in the urine are responsible for these various actions.

113. **Independence of the Peripheral Circulation.**—Hasebroek presents evidence to show that the relative width of the vessels does not determine the biologic conditions in regard to the peripheral circulation. He expatiates on the importance of the pulse wave and of the aspiration at the periphery and the relations between the latter and the central propelling impulse.

117. **Diabetes with Cancer in the Pancreas.**—Heiberg has found glycosuria mentioned in only three of thirty-five cases of pancreatic cancer whose records he had examined, and it was never very pronounced. In a case he reports in detail the diabetes was most probably primary, the same as in a case reported by Lépine in 1909. In both these cases the diabetes had existed for eighteen months and several years and the cancer was of comparatively recent development. Heiberg's patient was a man of 37.

Deutsche medizinische Wochenschrift, Berlin

May 25, XXXVII, No. 21, pp. 961-1008

119 *Bilateral Thrombosis of Femoral Veins After Severe Catarrh of the Large Intestine. B. Riedel.
120 *Tuberculosis of the Kidneys. (Ueber Nierentuberkulose.) A. Barth.
121 Acid-Agglutination of Bacteria, Especially of Typhoid Bacilli. L. Michaelis.
122 Changes in the Suprarenals with Growth. (Ueber den Umbau der Nebenniere im extrauterinen Leben.) H. Kern.
123 *Physical Forces in Treatment of Certain Internal Diseases. (Die physikalische Therapie bei einigen inneren Erkrankungen.) F. Klug.
124 Radiography of Calculi in Urinary Passages. (Untersuchungen über die röntgenologische Darstellbarkeit von Steinen des harnleitenden Apparates.) W. Telemann.
125 Vaccine Therapy. A. Strubell.
126 Salvarsan and Hemolysis. H. Meyer.
127 Pathogenesis of Hemorrhagic Purpura. S. Cannata.
128 The Pyloric Murmur. (Das Pylorusgeräusch.) S. J. Meltzer.

119. **Bilateral Femoral Thrombosis after Severe Intestinal Catarrh.**—Riedel reports two cases which suggest that thrombosis in certain obscure cases may be traced to a pre-existing intestinal affection. Both of his patients recovered, so he cannot prove the truth of his surmise as to the connection between the intestinal catarrh and the development of the thrombosis, but the features of the cases seem to sustain it. The first patient was a young housemaid and the primary trouble was a severe gastro-intestinal catarrh, with the large intestine predominantly affected. The onset was so sudden and stormy that appendicectomy was done at once but the appendix was found totally obliterated. Diarrhea continued after the operation and by the eighth day signs of thrombosis appeared. The second patient was a physician, 63 years old, whose right leg had been amputated on account of obstruction of the anterior tibial artery. He became extremely constipated from lack of the exercise that used to keep his bowels in good order, while he refrained from straining at stool for fear of injuring the healing of the stump. After three months he had vague discomfort and loss of appetite, slight chilliness, the tongue somewhat coated, and by chance his temperature was taken and found febrile, with pulse of 96, and the next day signs of serious auto-intoxication developed; the tongue and mouth were parched and the patient was constantly somnolent. Riedel comments parenthetically on the importance of this constantly dropping off to sleep as a sign of auto-intoxication, having observed it in an extreme type recently in a patient whose ileum had been united with the sigmoid flexure. The feces passed on into the colon and accumulated there instead of taking the short cut into the rectum. This patient could not keep awake until an artificial anus was made, which restored approximately normal conditions. In Riedel's second patient mentioned above the auto-intoxication was intense and the patient lost 24 pounds in two weeks. Then the thrombosis in both thighs was discovered. The patient had not complained of any pain. He gradually recovered and was able to resume his practice after three months, and by the fifth month he had regained his former weight and health. Riedel thinks it probable that colon bacilli may migrate from the intestine in case of catarrh or extreme constipation and pass into the mesenteric lymphatics and thence into the walls of minute veins. From this point thrombosis may develop down into the femoral veins by way of the hypogastric vein. In both his cases the thrombi were apparently entirely aseptic or only very slightly infected, judging from the outcome of the cases. One patient had typical obstructing thrombosis, the other probably only thrombosis at the valves, with transient piling up of blood-plates.

120. **Tuberculosis of the Kidneys.**—Barth has traced to date thirty-seven patients whose kidney he had removed on account of tuberculosis; three others died. During the same period he had about forty other patients with renal tuberculosis who were not given operative treatment for various reasons. Twelve of the thirty-seven patients recovered entirely after the nephrectomy and twelve were materially improved while thirteen have died. Analysis of the cases shows that as long as the tuberculous process is restricted to one kidney and its ureter, nephrectomy promises a complete cure. But if the bladder is involved, a cure can be anticipated in only 25 per cent. of the cases; 25 per cent. of his patients succumbed during the year to the progress of the tuberculosis.

The others all showed great improvement, but about 25 per cent. succumbed later to the tuberculosis, after an interval of from two to over nine years. Even when the tuberculous process in the bladder heals completely, it leaves permanent disturbances in the form of unduly frequent desires to urinate, particularly annoying at night. He admits the possibility of a spontaneous cure of open or closed tuberculosis of the kidney, but declares that there is not the least prospect of such a cure after the tuberculous foci begin to break down and pyuria appears. The process then spreads rapidly along the lymphatics in the kidney itself and down toward the bladder. It is impossible to determine the actual healing of a tuberculous process in the kidneys except by repeated catheterization of the ureter; all other signs and information are deceptive and worthless. Nephrectomy with unilateral tuberculosis, normal functioning of the other kidney understood, is, he affirms, almost entirely free from danger. It should be advocated in every case of open tuberculosis of the kidney and if possible before the bladder is invaded. The open tuberculous process in the kidney can be detected in the incipient and early stages only with the aid of the ureter catheter; chromocystoscopy does not locate the seat of the process unless there is advanced destruction of kidney tissue. It is important, therefore, to insist on catheterization of the ureters and bacteriologic examination of the urine in every obscure case of pyuria ("catarrh of the bladder").

123. **Employment of Physical Agents in Treatment of Internal Disease.**—Klug expatiates on the importance of induced hyperemia in treatment of internal disease, stating that dry warmth acts more superficially and slowly on the tissues, owing to its comparatively slight conducting power, while moist heat, on account of its remarkable conducting power rapidly penetrates through the organs of the body, and of all methods of application the steam douche is most effectual, according to his extensive experience. He remarks that the steam douche has had only stepmotherly consideration in the literature to date, and yet its field is broad. He applies it to fully a third of all his patients with internal diseases, and ascribes a large part of his success to it, emphasizing the excellent results obtained in twenty-four cases of disturbances in the liver or biliary passages, especially congestions and stasis, cholecystitis, catarrhal jaundice, gall-stone trouble and diffuse inflammation of the liver. The steam douche puts an end to the cramp of the vessels causing the colics and thus cures the pain. The pressure is about one atmosphere and a half, and he generally follows it with an alternating hot and cold fan douche. When there is persisting tenderness he applies a hot coil to the liver region through which water at a temperature of 45 C. (113 F.) is constantly running. His experience with the steam douche was equally favorable in five cases of kidney stone colic. The steam douche was applied for half an hour and followed by a bath at 35 C., all cooperating to relax the spasmodic contraction of the vessels. The steam douche frequently takes the place of and renders morphin unnecessary. The same principles have proved equally effectual in treatment of motor and secretory gastric neuroses, nervous dyspepsia and gastralgia, acute and chronic gastro-intestinal catarrh, and for atony and constipation. Hot packs to the stomach region with a hot coil act as a specific for nervous vomiting or dyspepsia and gastralgia, but the steam douche proved more effectual in the other conditions supplemented by massage and exercises. He adds that the steam douche is proving a valuable aid also in treatment of pulmonary tuberculosis, etc.

Medizinische Klinik, Berlin

May 28, VII, No. 22, pp. 839-874 and Supplement

129 *Occult Diseases. (Okkulte Erkrankungen innerer Organe.) N. Ortner.
130 Digitalis in Treatment of Typhoid. A. Skutetzky.
131 Pseudoleukemia. (Ueber einen klinisch eigenartigen Fall von Hodgkinscher Krankheit — vom Typus Sternberg — mit Fraenkel-Muchschem Bacilienbefund.) H. Luce.
132 *Mishaps with Intravenous Salvarsan Injections. (Zufälle bei intravenösen Salvarsaninjektionen.) Leven.
133 *Treatment of Persistent Hiccup. (Zur Behandlung des hartnäckigen Singultus.) P. Jödicke and G. Rethy.
134 Research on Effect of Climate. (Zur Methodik der Klimaforschung.) N. Zuntz.
135 Importance of Hormones for Internal Medicine. L. Borchardt.

129. **Occult Diseases.**—Ortner applies this term to an affection which is masked by some other more prominent one, and describes a number of instructive cases of this kind from his personal experience. Behind pulmonary emphysema may be hidden an aneurysm of the aorta or a hydrothorax; behind an acute or chronic insufficiency of the myocardium, there may be unsuspected exophthalmic goiter. His observation has shown that pronounced venous stasis without arrhythmia but accompanied by considerable tachycardia may be explained by injury of the heart from unsuspected exophthalmic goiter. Still more difficult to explain are the cases in which miliary tuberculosis is masked by insufficiency of the myocardium. In one such case fatty degeneration of the heart was assumed until the necropsy. In this as in a number of the other cases described, the mere conception of the possibility of the occult disease gives the clue to its discovery. Pernicious anemia and leukemia may be hidden beneath the clinical manifestation of cardiac insufficiency, anasarca, tender, enlarged liver with urobilinuria, dilatation of the heart and signs of relative mitral and tricuspid insufficiency. Neglect to examine the blood leads inevitably to diagnostic blunders. To detect a hidden hydrothorax, he has found it useful to determine the lower, rear limit of the lungs after the patient has been reclining flat for a long time. The lower limit will be found very high but after the patient has been erect for a time the fluid flows forward and the lung is low again. He warns that he has often found a copious pleural effusion persisting for months behind the retracted part of the thorax drawn in by the newly formed connective tissue on the pleura. Exploratory puncture, evacuation of the accumulated fluid, rendered complete by pumping in of air—these are the only certain means to reveal and cure these cases in which tuberculosis is often imagined and the patient sent to sanatoriums. The subfebrile temperature and disturbances keep up, however, until the purulent fluid behind the thickened pleura is discovered and released. Another occult affection is an ulcer at the pylorus causing very slight stenosis; the stomach is able usually to expel its contents but under special stress it fails. Conditions of this kind are best revealed by a test meal of a quantity of some food difficult to digest, the *Belastungsmahlzeit*, as he calls it.

132. **By-Effects After Injection of Salvarsan.**—Leven has reported a case of transient collapse after intravenous injection of salvarsan and here reports a still more serious case. An intravenous injection of 0.3 gm. of salvarsan, in a middle aged patient was followed at once by cyanosis and nausea and the face swelled enormously and the tongue became too large to pass between the lips. Intense headache and retching completed the picture, but the symptoms subsided after twenty minutes except for the swelling in the face. By the next morning nothing was left of the disturbances but moderate edema of the eyelids. The pulse and temperature had been persistently normal.

133. **Treatment of Obstinate Hiccup.**—Jödicke as a last resort in the very serious case reported, the patient so exhausted that he had been brought to the hospital, had the legs flexed on the abdomen and pressed them against the abdomen so that the intestines were forced up against the diaphragm as much as possible. The hiccups became at once weaker and the intervals longer and in ten minutes the hiccup had ceased entirely. They began again after two hours but were arrested anew by the same measure. The principle is the same as Kannegiesser's method of forcing up the diaphragm by the gases formed by effervescence in the stomach. Jödicke has applied his method again in several other cases and with equal success. Rethy reports good effects also from pressure applied along the entire spine.

Monatsschrift für Kinderheilkunde, Leipsic

April, X, No. 1, pp. 1-54

136 Metabolism of the Artificially-Fed Infant During First Days of Life. (Zur Physiologie des neugeborenen Kindes. IV.) W. Birk.
137 Treatment of Rachitis with Cod Liver Oil Emulsions and Their Action on the Metabolism. J. A. Schabad and R. F. Sorochowitsch.
138 Influenzal Whooping-Cough. (Zur Aetiologie des Keuchhustens.) E. Welde.
139 Behavior of Leukocytes in Tuberculosis in Children. (Verhalten der weissen Blutkörperchen bei kindlicher Tuberkulose.) H. Hirschfeld.

Münchener medizinische Wochenschrift

May 23, LVIII, No. 21, pp. 1113-1168

140 Theoretical and Practical Aspects of the Newer Electrophysiology. M. Gildemeister.
141 *Blood-Pressure Raising Properties of the Hypophysis Cerebri. (Ueber die therapeutische Anwendung von Pituitrin — Hypophysenextrakt—mit bes. Berücksichtigung seiner blutdrucksteigernden Komponente.) R. Klotz.
142 *Epinephrin in Peritonitis. (Die pharmokologischen Grundlagen für eine intravenöse Adrenalintherapie bei der Peritonitis.) E. Holzbach.
143 *Determination of Very Slight Albuminuria. (Zur Methodik des Nachweises sehr kleiner pathologischer Eiweissmengen im Harn.) O. Glaesgen.
144 *Irritation of the Kidneys by the Salicylates and Its Avoidance by Giving Alkalines. (Ueber Nierenreizung durch Salizylpräparate und ihre Aufhebung durch Alkalizufuhr.) O. Glaesgen.
145 Property of Human Organs to Render Air a Conductor for Electricity. (Fähigkeit menschlicher Organe, die Luft für Elektrizität leitend zu machen.) A. Caan.
146 Treatment of the Heart with High Frequency Oscillating Currents. (Zur Rumpfschen Herzbehandlung mit hochfrequenten oszillierenden Strömen.) G. Hunerfauth.
147 *Diagnostic Importance of Palpable Glands in Children's Arms. (Fühlbare Kubitaldrüsen bei Kindern.) P. Grosser and A. Dessauer.
148 Improved Technic for Leukocyte Count and Cytodiagnosis. (Eine erweiterte Zahlkammer für Leukozytenzählung und Zytodiagnostik.) R. Dunger.
149 The Hematocrite Blood-Count Method. (Bestimmung der Masse der roten Blutkörperchen durch Zentrifugieren.) R. Schmincke.
150 Salvarsan in Frambesia, Leprosy and Tropical Granuloma. G. Rost.
151 Dry Versus Moist Rubber Gloves. (Gummihandschühe.) Schede.
152 To Prevent Caustic Action of Benzine. (Zur Aetzwirkung des am Verdunsten verhinderten Benzins.) A. Hörrmann.

141. **Hypophysis Extract.**—Klotz writes from Sellheim's clinic to describe experimental research and clinical experiences with an extract made from the hypophysis. He states that it induces a moderate rise in blood-pressure, lasting for several hours, with only slight demands on the heart. At the same time it stimulates the heart and peristalsis and also the bladder and increases the output of urine while it proves a stimulant for the uterus and the cardiovascular system in general. He adds that the extract is not a harmless, innocent substance by any means, and it should not be used when the blood-pressure is already high or the cardiovascular system out of order at any point. By intramuscular injection the action is speedy, and he does not think that any injury of the human organism under moderate dosage need be feared.

142. **Epinephrin in Peritonitis.**—Holzbach found that prolonged instillation of a very weak saline epinephrin solution was able to keep the blood-pressure at the normal height in peritonitis with a tendency to collapse, and do this without harm. Injection of a single dose in a concentrated solution is not only dangerous but does little good as the action of the epinephrin is transient. His clinical experience has confirmed the results of his experimental research in this line.

143. **Determination of Minute Amounts of Albumin in the Urine.**—Glaesgen adds 5 drops of a 20 per cent. solution of acetic acid to 20 c.c. of urine and then pours half into each of two beakers. The contents of one beaker are boiled, the other not. By this means the slightest tendency to coagulation of albumin in the boiled fluid is readily apparent.

144. **Alkalines to Prevent Injury of Kidneys During Salicylic Medication.**—Glaesgen found the sensitive test described in the preceding abstract extremely useful to determine injury of the kidney under the salicylates. Albuminuria was the rule, but this could be prevented by giving an alkali at the same time. About twice as much of the alkali as of the salicylate was necessary to neutralize it. The therapeutic action of the salicylates did not seem to be modified by the alkali, and the sodium bicarbonate even in doses of from 6 to 10 gm. (90 to 150 grains) a day did not seem to induce any disturbances; this amount was necessary to actually reduce the acidity of the urine.

147. **Diagnostic Importance of Enlarged Glands in the Arms of Children.**—Grosser and Dessauer examined 1,897 children for the presence of palpable supratrochlear lymph nodes, finding them equally frequent in the children with inherited syphilis and in those with rachitis. In those without syphilis or tuberculosis only 5.6 per cent. of the 1,037 infants and 7.8 per cent. of the 711 children over a year old had enlarged trochlear glands, while 19.2 per cent. of the 94 older children presented them. These findings show that palpable nodes in this region cannot be accepted as pathognomonic of syphilis.

Wiener klinische Wochenschrift, Vienna

May 18, XXIV, No. 20, pp. 695-748

153 *Appendicitis in Children. (Ueber Blinddarmentzündung beim Kinde.) H. Salzer.
154 *Intravascular Transplantation. G. Joannovics.
155 *Latent Pyelonephritis in Women. F. Kermauner.
156 Treatment of Acute Infectious Diseases with Salvarsan. F. Lucksch.
157 *Experimental Research on Cutaneous Reactions. F. Luithlen.
158 *Chorio-Epithelioma. F. Hitschmann and R. Cristofoletti. Commenced in No. 19.

153. **Appendicitis in Children.**—Salzer comments on the high mortality of appendicitis in children. Kümmell cites it at 11, 19 and up to 30 per cent., and in Salzer's 200 cases, thirty-five of the children were apparently cured by internal measures alone, two were moribund and 163 were given operative treatment with twenty-two deaths, a total mortality of 12 and operative mortality of 13 per cent. He insists that this excessive mortality is due solely to the fact that the trouble is not recognized early enough. People are too apt to regard gastro-intestinal disturbances in children as a matter of course and not as frequently a symptom of a serious affection. An early operation should be recommended even more energetically than for adults, as children must be protected against the indolence of their environment.

154. **Intravascular Transplantation.**—Joannovics reports some interesting experiments on cats injected with ground parathyroid and thyroid tissue in the jugular vein, with or without preceding thyroidectomy. In one animal tetany following thyroidectomy subsided under thyroid treatment.

155. **Latent Pyelonephritis.**—Kermauner calls attention to Göppert's important research on pyelocystitis in children, especially in infants; 89 per cent. of the children thus affected were girls. Interesting further is Heubner's assertion that pyelitis is especially frequent in children who have had some mild infectious disease, measles or varicella. In infants the pyelocystitis is most frequent in the second half of the first year and it seems to heal, but it recurs before puberty in about 20 per cent., and Kermauner thinks that it probably persists in a latent form for years when the colon bacillus is involved. This bacillus seems to thrive in the urine, while the urine is bactericidal for other bacteria. This demonstrates, he thinks, that colipyelitis may be traced into early childhood and that it may flare up after prolonged latency in consequence of some intercurrent injury. The menstrual periods may influence it to some extent, but the greatest influence is exerted by a pregnancy. This is liable to act as an intercurrent injurious influence bringing on an acute attack in some cases or merely aggravating the latent pyelitis. He reports a case in a woman of 30 who had had measles three times during childhood, and during menstruation had always experienced intense tenesmus and smarting in the vagina. At the fifth month of the pregnancy there was severe pain in the right kidney region for a few days, with turbid urine, but no fever and there is still a sense of oppression in the kidney region. He explains the case as a latent pyelonephritis, and recommends in such cases internal treatment with hexamethylenamin, although he does not think that an actual cure can thus be realized. If this medication clears up the urine, the diagnosis of latent pyelonephritis is rendered more probable. He does not advocate catheterization of the ureter and lavage of the pelvis unless the attack lasts for more than a week or is unusually severe. With latent pyelitis, local measures are best deferred until after the childbirth.

157. **Cutaneous Reactions in Animals.**—Luithlen has been experimenting with cats and dogs, watching the local reaction on their shaved backs to irritating substances after the animals had been taking hydrochloric acid, sodium oxalate or calcium chlorid. Under the influence of this medication the skin became much more sensitive to irritation from without; with the calcium chlorid the tendency to exudation was materially reduced. The skin is evidently modified from within, and the response to irritation can thus be varied at will.

158. **Chorio-Epithelioma.**—The first part of this article was reviewed in THE JOURNAL, June 17, page 1864. A case is here described in which vaginal hysterectomy was attempted for

malignant chorio-epithelioma, the patient a woman of 32, but conditions were found inoperable. Examination four weeks after the operation disclosed that the growth had disappeared and that the uterus was movable; the woman has been in good health during the eight years since. Study of this case shows that the thrombosed veins evidently prevented the spread of the chorio-epithelioma, the malignant tissue losing its vitality in the thrombosed vessels. The aim should be to reproduce similar conditions to restrict the growth to the region first involved. For this he recommends ligation of the efferent veins as a preliminary to abdominal hysterectomy, with great care to refrain from artificially inducing embolism.

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II, No. 1, pp. 1-122. Last indexed May 13, p. 1431

159 Distribution of Nitrogen in the Urine of New-Born Infants. (Zur Stickstoffverteilung im Urin des Neugeborenen.) S. Simon.

160 Physiology of Nutrition of Prematurely Born Infants. (Beiträge zur Physiologie der Ernährung von frühgeborenen Kindern.) S. Samelson.

161 Biologic Tests for Casein in Infants' Stools. (Nachweis des Caseins in den sogenannten Caseinbröckeln des Säuglingsstuhls mit Hilfe der biologischen Methodik, insbesondere der Anaphylaxie.) Uffenheimer and Y. Takeno.

162 Internal and External Temperature in Infants. (Ueber Stamm- und Hauttemperaturen bei Säuglingen.) H. Schelble.

163 *Incubation of Measles. (Cytologische und klinische Beobachtungen während der Maserninkubation.) R. Hecker.

164 Influence of Phosphorus Cod-Liver Oil on Metabolism of Rachitic Infants. (Bemerkungen zur der Arbeit von Dr. Caroline Towles: Untersuchungen über den Einfluss des Phosphorlebertrans auf den Stoffwechsel eines rachitischen Säuglings.) J. A. Schabad.

163. Incubation of Measles.—Hecker tabulates the findings in fourteen children whose blood was examined during the incubation period of measles. The temperature was found to vary widely even in the earliest stages and the blood showed pronounced reduction of white corpuscles, fully four and one-half days before the eruption and three and one-half days before Koplik's spots were manifest. Two or three days before the eruption the leukocyte count increased. In one of the cases the period of incubation was sixteen and in another twenty days. The tables confirm the resemblance between measles and serum sickness after the first injection, both a specific reaction, of the same type.

Zentralblatt für Chirurgie, Leipsic

May 20, XXXVIII, No. 20, pp. 693-724

165 Technic for Local Anesthesia. B. Hammer.

Zentralblatt für Gynäkologie, Leipsic

May 20, XXXV, No. 20, pp. 737-768

166 *Remarkable Resistance of the Peritoneum. (Seltene Widerstandsfähigkeit des Peritoneums.) S. S. Cholmogoroff.

167 Absorbing Power of Various Body Cavities. (Resorptionsvermögen diverser Körperhöhlen.) A. Czyzewicz.

168 Inefficacy of Local Chemical Means for Preventing Conception. (Experimenteller Beitrag zur Verhütung der Konzeption durch chemische Mittel.) E. Kraus.

166. Resistance of the Peritoneum to Trauma.—In the two cases reported the laparotomy wound after Cesarean section burst open without the patient's knowledge and the condition was not discovered until the dressings were changed the next day, but no symptoms of peritonitis followed in one case. The other patient died. Cholmogoroff knows of only twenty-three similar cases on record of complete bursting open of the laparotomy wound. It occurs without pain so that the patients seldom recognize that anything is wrong at the time. In the twenty-one cases in which the outcome is known, five of the patients died. After the peritoneum has been exposed to the air and to contact with a foreign substance, such as gauze or body linen, it seems to acquire a certain resisting power so that it may bear drying out and even lack of asepsis and considerable traumatism without reacting with diffuse peritonitis or ileus.

Gazzetta degli Ospedali e delle Cliniche, Milan

May 23, XXXII, No. 62, pp. 659-666

169 Experimental Research on Action of Drugs on Heart. (Intorno all'applicazione del metodo cardiovolumetrico—fistola pericardica—allo studio dell'azione dei farmaci e delle sostanze chimiche in genere sul cuore.) A. Berti and A. Malesani.

May 25, No. 63, pp. 667-674

170 Treatment of Epilepsy with Nerve Tissue Extract. C. Trevisanello.

Books Received

Books received are acknowledged in this column and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for review in the interests of our readers and as space permits.

ANNUAL REPORT OF THE SANITARY COMMISSIONER WITH THE GOVERNMENT OF INDIA FOR 1909. With Appendices and Returns of Sickness and Mortality Among European Troops, Native Troops and Prisoners in India for the Year. Paper. Price, 3 rupees. Pp. 147. Calcutta: Superintendent Government Printing, India, 1911.

MENTAL MECHANISMS. By William A. White, M.D., Author of "Outlines of Psychiatry," Superintendent Government Hospital for the Insane, Washington, D. C. Nervous and Mental Disease Monograph Series No. 8. Paper. Price, $2. Pp. 151. New York: The Journal of Nervous and Mental Disease Publishing Co., 1911.

DIE PALPABLEN GEBILDE DES NORMALEN MENSCHLICHEN KÖRPERS UND DEREN METHODISCHE PALPATION. Nach eigenen Untersuchungen an der Leiche und am Lebenden von Dr. Toby Cohn, Nervenarzt in Berlin. III Teil: Hals und Kopf. Paper. Price, 8 marks. Pp. 585, with 92 illustrations. Berlin: S. Karger, 1911.

HANDBOOK OF DISEASES OF THE EYE. A Text-Book for Students and Practitioners. By Harry Caldwell Parker, M.D., Clinical Professor of Ophthalmology, Indiana University School of Medicine, Indianapolis, Ind. Cloth. Price, $2 net. Pp. 303, with 116 illustrations. Philadelphia: F. A. Davis Co., 1910.

KURZGEFASSTE CHIRURGISCHE OPERATIONSLEHRE (OPERATIONSKURS). Für Studierende und Aertze. Von. Ad. Oberst, Assistent an der Chirurg. Klinik und Privatdozent für Chirurgie an der Universität Freiburg i. Br. Paper. Price, 7 marks. Pp. 198, with 232 illustrations. Berlin: S. Karger, 1911.

REFRACTION AND MOTILITY OF THE EYE. With Chapters on Color-Blindness and the Field of Vision. Designed for Students and Practitioners. By Ellice M. Alger, M.D., Adjunct Professor of Ophthalmology at the New York Postgraduate Medical School. Cloth. Price, $1.50 net. Pp. 376, with 122 illustrations. Philadelphia: F. A. Davis Co., 1910.

A TEXT-BOOK OF CHEMISTRY. For Students and Practitioners of Medicine, Pharmacy and Dentistry. By Edward Curtis Hill, M.S., M.D., Medical Analyst and Microscopist. Second Edition. Cloth. Price, $3.25. Pp. 659, with 114 illustrations. Philadelphia: F. A. Davis Co., 1911.

INTERNAL SECRETIONS FROM A PHYSIOLOGIC AND THERAPEUTIC STANDPOINT. By Isaac Ott, A.M., M.D., Professor of Physiology in the Medico-Chirurgical College of Philadelphia. Cloth. Price, $1. Pp. 133, with illustrations. Easton, Pa.: E. D. Vogel, 1910.

NEURASTHENIA. By Gilbert Ballet, Professeur *agrégé* à la Faculté de Médecine de Paris. Translated from the Third French Edition by P. Campbell Smith, M.D. Third Edition. Cloth. Price, $3 net. Pp. 408. New York: William Wood & Co., 1911.

THE HOUSE-FLY, DISEASE-CARRIER. An Account of Its Dangerous Activities and of the Means of Destroying It. By L. O. Howard, Ph.D. Cloth. Price, $1.60 net. Pp. 312, with 35 illustrations. New York: Frederick A. Stokes Co., 1911.

UEBER SCHARLACH (DER SCHARLACHERKRANKUNG ZWEITER TEIL). Von Dr. Dionys Pospischill, k. k. Primararzt, und Dr. Fritz Weiss, gew. Assistent der Abteilung. Paper. Price, 5 marks. Pp. 147. Berlin: S. Karger, Karlstrasse 15, 1911.

YEAR-BOOK OF THE PILCHER HOSPITAL. For the Period from March 16, 1910, to March 31, 1911. Being the First Year of the Operation of the Hospital. Paper. Pp. 691, with illustrations. 145 Gates Avenue, Brooklyn, N. Y.

PSYCHIATRISCHE VORTRÄGE FÜR AERZTE, ERZIEHER UND ELTERN. (Zweite Serie). Von Prof. Dr. G. Anton, Direktor der Klinik für Geistes- und Nervenkranke in Halle a. S. Paper. Price, 2 marks. Pp. 77. Berlin: S. Karger, 1911.

THREE THOUSAND YEARS OF MENTAL HEALING. By George Barton Cutten, Ph.D. (Yale), President of Acadia University. Cloth. Price, $1.50 net. Pp. 318, with illustrations. New York: Charles Scribner's Sons, 1911.

REPORTS FROM THE LABORATORY OF THE ROYAL COLLEGE OF PHYSICIANS, EDINBURGH. Edited by Sir John Batty Tuke, M.D., and James Ritchie, M.D. Volumes X and XI. Cloth. Edinburgh: Oliver & Boyd, 1911.

HANDBUCH DER BIOCHEMIE DES MENSCHEN UND DER TIERE. Herausgegeben von Dr. Carl Oppenheimer in Berlin. Twenty-Eighth Instalment. Paper. Price, 5 marks. Pp. 553-712. Vienna: Gustav Fischer, 1911.

JOINT TUBERCULOSIS. By Leonard W. Ely, M.D., Consulting Orthopedist to the County Hospital, Denver. Cloth. Price, $2.50 net. Pp. 243, with 72 illustrations. New York: William Wood & Co., 1911.

PRÉCIS D'ELECTROTHÉRAPIE ET DE RADIOTHÉRAPIE OCULAIRES. Par le Dr. A. Leprince (de Bourges). Paper. Price, 3 fr. 50. Pp. 316. Paris: Jules Rousset, 12 Rue Monsieur-le-Prince, 1911.

ANNUAL REPORT OF THE HOSPITAL AND OUTDOOR DISPENSARY ATTACHED TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF CALCUTTA. For the Year 1909. Paper. Pp. 13.

STUDIES IN THE PSYCHOLOGY OF SEX. VOL. VI. SEX IN RELATION TO SOCIETY. By Havelock Ellis. Cloth. Price, $3 net. Pp. 655. Philadelphia: F. A. Davis Co., 1911.

A LIST OF BOOKS ON THE HISTORY OF SCIENCE, THE JOHN CRERAR LIBRARY. January, 1911. Prepared by Aksel G. S. Josephson, Cataloguer. Paper. Pp. 297. Chicago, 1911.

CONTRIBUTIONS FROM THE WILLIAM PEPPER LABORATORY OF CLINICAL MEDICINE. University of Pennsylvania. (Reprints). No. 7. Philadelphia, 1909-1910. Paper.

SIXTEENTH REPORT OF THE BOARD OF HEALTH OF THE TOWN OF MONTCLAIR, N. J. From Jan. 1, 1910, to Dec. 31, 1910. Paper. Pp. 67.

ANNUAL REPORT OF THE CANTON HOSPITAL AND THE SOUTH CHINA MEDICAL COLLEGE FOR THE YEAR 1910. Paper. Pp. 35.

CALENDAR OF THE UNIVERSITY OF ADELAIDE. For the Year 1911. Cloth. Price, 2 shillings 6 pence. Pp. 453.

REPORT OF THE NEW YORK STATE VETERINARY COLLEGE FOR THE YEAR 1909-1910. Paper. Pp. 220.

PROCEEDINGS OF THE LOS ANGELES SESSION

MINUTES OF THE SIXTY-SECOND ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION, HELD AT LOS ANGELES, CAL., JUNE 26-30, 1911

HOUSE OF DELEGATES

First Meeting—Monday Morning, June 26

The House of Delegates met in the auditorium of the Armory, Los Angeles, Cal., at 10:15 a. m., and was called to order by the President, Dr. William H. Welch, Baltimore.

Dr. D. Chester Brown, Connecticut, presented a preliminary report of the Committee on Credentials. No objection being raised, the report of the committee was accepted.

The Secretary called the roll, and a quorum was present.

The next in order was the reading of the minutes of the Sixty-First Annual Session, which were approved.

Opening Address to House

President Welch then addressed the House of Delegates, speaking as follows:

"The creation of the House of Delegates as a relatively small but sufficiently representative body for legislative action and for the transaction of necessary business is unquestionably one of the greatest improvements which was introduced by the organization effected years ago. In contrast with the old day, effective action of the Association is now made easy, but the very readiness with which suggestions and recommendations from the most varied sources and of every degree of merit can now gain a hearing and legislation can be enacted, carries with it some measure of those possibilities of good and of evil which in an analogous situation are reflected in the hopes and the fears of the people when our federal, state and municipal legislatures are in session.

"So large and potential for good are the powers and responsibilities entrusted to the House of Delegates that too much emphasis cannot be laid on the duty of the constituent associations and sections to select as their representatives the best and wisest men available for the purpose, and such men should be willing at least to take their turn in serving in this capacity. Of the multitude of recommendations and proposals presented, only a relatively small number, even of commendable ones, can be adopted, and the selection of those most worthy requires much wisdom and careful consideration.

Among the considerations which should influence this choice and determine action are the relations of the end in view, however desirable in itself, to the scope and objects of the Association, the broad, national interest, the importance and the timeliness of the proposal, the possibility of obtaining in a reasonable time really valuable results with the men and the resources at command, the concentration of effort on promising projects once undertaken as contrasted with the dispersion of energy and of funds over too large an area and the avoidance of duplication of work already provided for by various other agencies, with which, however, our cooperation may constitute a most useful form of activity.

As regards matter within the special province of the House of Delegates, the methods most appropriate for the Association to follow and best calculated to secure in the long run enduring results have been well exemplified in the activities of some of the councils and special committees, and have consisted mainly in the thorough study and investigation of conditions and of remedies and in the education of the profession and the public by conferences, reports and published papers and pamphlets. Such are, in my judgment the most fitting and useful direction for the activities of the Association in matters relating to public health and medical and sanitary legislation, where it should be made clear that the medical profession has no interest different from that of the community in general, viz.: the preservation and promotion of the health of the people. We may expect, I believe, large and beneficial results from the work of the Council on Health and Public Instruction, constituted at the last annual session, along lines such as those indicated.

As President, I have recently received a letter from Major-General George W. Davis, chairman of the Central Committee of the American Red Cross, requesting that a committee of the American Medical Association be appointed to consult and advise with a committee of the American Red Cross as to the best arrangements to be made for medical relief in times of disaster. We should esteem it a privilege to cooperate with the Red Cross for such a humane purpose, and I therefore beg to submit to the Reference Committee on the Reports of Officers, with my approval, General Davis' letter which contains certain specific suggestions regarding the proposal.

I desire especially to call the attention of the House to an interesting suggestion, first publicly made, so far as I am aware, by the late Dr. Ellis of Maryland and endorsed by the Medical and Chirurgical Faculty of that state by a resolution referring it to this body. The suggestion is that in connection with the proposed celebration of the completion of the Panama Canal in 1915, there shall be suitable commemoration of the greatest triumph of modern times in the domain of preventive medicine. The sanitary problems in the construction of the canal, were, to say the least, not less difficult, and their triumphant solution constitute an achievement not less memorable, than the problems and the accomplishment of the engineer. It is the glory of American medicine to have contributed through Reed and Carroll and their colleagues the scientific discoveries—and through my predecessor in this office, Colonel Gorgas, the practical application of these discoveries—which will have made possible without large sacrifice of lives the completion of the stupendous undertaking to be celebrated in this state four years hence. This celebration will be neither complete nor worthy without the fullest recognition of the contributions of sanitary science to the successful completion of the isthmian canal. I venture the suggestion that an International Congress of Tropical Medicine, to be held in connection with the Panama-Pacific Exposition in 1915, would afford an opportunity worthily to commemorate the conquest over pestilential diseases on the isthmus and elsewhere in the tropics. I recommend that a special committee be appointed to consider the best mode of commemorating the sanitary work and achievements attending the construction of the isthmian canal, and that this committee be provided with the funds and the authority necessary to the attainment of the desired end.

After his address, President Welch announced the Reference Committees for this session.

Report of the Secretary

The Secretary presented his annual report, which was referred to the Reference Committee on Reports of Officers. It was as follows:

To the Members of the House of Delegates of the American Medical Association:

I submit herewith the secretary's report for the year 1910-1911:

MEMBERSHIP

The membership of the American Medical Association on May 1, 1910, was 34,176. During the past year 335 members have died, 222 have resigned, 462 have been dropped as not eligible, 1,849 have been dropped for non-payment of dues, and 48 have been removed from the rolls on account of being reported as "not found," making a total of 2,916 names to be deducted from the membership list. There have been added 2,700 names to the membership list, of which 2,294 were transferred from the subscription list. The membership of the American Medical Association on May 1, 1911, was 33,960, a net loss for the year of 216.

This would be discouraging without explanation. In their reports, the Trustees have frequently referred to the fact that membership was being recruited almost entirely from those who at first were listed as subscribers. In other words, until the last year, continued efforts were made to get those who were taking THE JOURNAL as subscribers and who were eligible to membership in the American Medical Association to have their names transferred to the membership rolls. For the past year, however, we have relaxed our efforts in this direction on account of the uncertainty of the final ruling of

the Post-Office Department regarding the mailing of THE JOURNAL to members as such.

MEMBERSHIP OF STATE ASSOCIATIONS

The membership of the various constituent state associations, according to the records in the Secretary's office, May 1, 1911, is shown in the accompanying table:

Component Association in the State of	No. of Counties in State.	No. of Component Societies in State Assn.	Counties not Organized.	No. of Members Reported May 1, 1911.	No. of Members Reported May 1, 1910.	Number gained.	Number lost.
Alabama	67	67	..	1,676	1,738	..	62
Arizona	13	7	6	157	131	26	..
Arkansas	75	63	9	963	989	..	26
California	58	36	21	1,972	2,057	..	85
Colorado	60	25	29	822	811	11	..
Connecticut	8	8	..	841	803	38	..
Delaware	3	3	—	103	108	..	5
District of Columbia	..	..	..	550	548	2	..
Florida	46	24	22	341	339	2	..
Georgia	146	86	32	1,169	1,145	24	..
Idaho	23	4	6	124	116	8	..
Illinois[1]	102	95	3	5,616	5,404	212	..
Indiana	92	87	4	3,107	2,550	557	..
Iowa	99	97	1	1,961	2,081	..	120
Kansas	105	74	17	1,452	1,376	76	..
Kentucky	119	112	6	1,863	1,986	..	123
Louisiana	59	39	18	893	1,068	..	175
Maine	16	13	3	577	574	3	..
Maryland	24	22	2	1,122	1,107	15	..
Massachusetts[2]	14	18	..	3,302	3,302	89	..
Michigan	83	58	6	2,092	2,300	..	208
Minnesota	85	38	..	1,207	1,220	50	..
Mississippi	78	50	8	965	1,001	..	36
Missouri[3]	114	94	15	3,073	2,862	211	..
Montana	28	10	16	234	201	33	..
Nebraska	91	62	26	1,026	1,001	25	..
Nevada	14	6	8	89	59	30	..
New Hampshire	10	10	..	540	594	..	54
New Jersey	21	21	..	1,404	1,340	64	..
New Mexico	26	14	12	246	237	9	..
New York	61	57	3	6,885	6,755	130	..
North Carolina	98	87	4	1,137	1,141	..	4
North Dakota	46	14	5	400	376	24	..
Ohio[4]	88	87	1	3,866	3,934	..	68
Oklahoma	75	68	6	1,122	1,309	..	177
Oregon	34	12	2	445	391	54	..
Pennsylvania[5]	67	63	4	5,487	5,351	136	..
Rhode Island	5	5	..	357	367	..	10
South Carolina	41	40	..	760	740	20	..
South Dakota	64	9	7	265	341	..	76
Tennessee	96	63	33	1,400	1,253	157	..
Texas	243	143	77	3,145	3,080	65	..
Utah	27	6	21	195	210	..	15
Vermont	14	11	3	410	398	12	..
Virginia[6]	100	..	..	1,604	1,604	..	..
Washington	38	23	10	934	870	64	..
West Virginia	55	31	11	861	971	..	110
Wisconsin	71	55	2	1,820	1,730	90	..
Wyoming	15	5	10	122	123	..	1
Canal Zone	..	..	..	72	..	..	..
Hawaii	..	..	..	78	58	20	..
Philippine Islands	..	..	..	103	95	8	..
Totals	2,917	2,016	489	71,118	70,146		

NOTE.—The number of members of the different associations stated in this table and the record of gain or loss in membership is in accord with the membership of the several associations as they were reported to the Secretary on the first day of May of 1910 and of 1911.

The lack of an effective uniform system for reporting the membership of the state associations accounts for whatever discrepancies this table shows and detracts from the value of the statement.

Component societies are those societies which compose the state association. A component society may include one county or more.

1. Chicago (Cook County) Medical Society includes both Cook and Du Page counties.

2. Massachusetts is divided into district societies, and these are listed in the table as component societies. Some of these districts are smaller and some larger than the county, the county lines being ignored.

3. There are two component societies in St. Louis County—the St. Louis City and the St. Louis County Medical Societies, each, however, covering definite territory.

4. This county was organized, but the society has recently been suspended.

5. Provision is made for the physicians in each of these counties to join the component society in an adjoining county.

6. Virginia has not adopted the plan of organization. Hence, strictly speaking, it has no component county societies. Members join the state society direct. Estimating the membership of the Virginia Medical Society as 1,604 for each year, the total membership of the organization would be 71,118, an increase over the number reported in 1910 of 972.

ASSOCIATE MEMBERSHIP

Last year the House of Delegates, on the recommendation of the Reference Committee on Constitution and By-Laws, made several modifications in the By-Laws which, if carried out, will interfere seriously with the scientific work of several of the Sections. Until the changes to which I refer were made, we had three classes of associate members, i. e., dentists, pharmacists and scientists, the latter being provided for as follows:

"Representative teachers, students of the sciences allied to medicine, resident in the United States, and not eligible to regular membership, may become associate members of this Association on recommendation of the officers of the Section and on election by the House of Delegates."

Under the provision of the By-Laws, as modified last year, the last-named class of associate members seems to have been eliminated entirely. The present Section 7, Chapter 1, provides for associate members and includes dentists and pharmacists, but there is no provision whatever for the very class of men who help some of the Sections so much. In fact, if this provision is carried out, it will seriously handicap one or two of the Sections, as these Sections have developed as the result of the work of this class of associate members. The chairman of the Section on Pathology and Physiology wrote: "It will never be possible to enlist the support of physiologists with the heartiness that I should like to see until they are convinced . . . that they are among the 'ins' instead of the 'outs'."

Another very important point should be noticed: there is no definition of these associate members. Are they to pay dues and receive THE JOURNAL, as did the old associate, dental and pharmaceutical members? If so, it should be so provided. The old By-Law provided in the old Section 4, Chapter III, Book I, that these associate members "shall enjoy the same privileges as regular members, and shall be subject to the same conditions." The new By-Law contains no definition whatever, so that, to use a slang expression, the "associate" members are "up in the air" as to where they stand.

I appeal to you to restore the old conditions. This can be done by striking out the present "Book 1, Membership," as it appears in the appendix of the Handbook, and substituting that which was "book 1—Membership" prior to the meeting of 1910; except that the words "one of," which followed "retains" in the third line of Section 2, Chapter I of the old by-laws, have been omitted.

UNIFORM REGULATION OF MEMBERS AND TRANSFERS

Ten years have passed since the report of the Committee on Reorganization was adopted at St. Paul; yet the principles that this report emphasized as fundamental have not been carried into effect. I refer particularly to the plan for the transfer of membership from one component society to another, in any state, and the uniform system for recording membership in the various states. The St. Paul report emphasized the principle that when a physician joined his county society he became a member of the "organization;" that no matter where he might go, his membership should follow him. This has not been carried into effect. A member who moves is compelled to seek membership in the society at his new location as though he had never held membership in the organization. Such a condition exists in no other body, so far as I know. Whether it be a trades union, a fraternal order, or a church, a member retains his connection with the organization wherever he may be, and can be transferred without trouble, when he moves from one location to another. A Committee on Uniform Regulation of Membership was appointed in 1908; it made a preliminary report in 1909, and another last year. This year, it recommends that it be re-created, and empowered and directed to perfect a plan for the uniform regulation and transfer of membership. I urge that this recommendation be adopted, for some such plan is vital to effective organization. I am sure that the constituent state associations will give their loyal cooperation.

JUDICIAL COUNCIL

Another matter closely related to the above deserves careful consideration. A reading of the transactions reveals the fact that from the beginning questions of an ethical nature were continually presenting themselves to the association. It is also evident that those that were complex or difficult were seldom or never squarely met. At first such matters were referred to a committee appointed at the annual session, and known as the Committee on Ethics. Experience showed, however, that there was not time at the annual sessions to investigate many of the questions that came up, and that a tem-

porary committee was not satisfactory. Hence, in 1874, a permanent, continuous body—the Judicial Council—was created. It was presumed, of course, that if necessary this Council would hold meetings in the interval between the annual sessions. Such meetings, however, would necessitate either that the Association should pay the expenses of the members, or that the individuals should pay their own expenses. The former was out of the question on account of lack of funds; the latter was not to be expected. And no such meetings were held.

In the reorganization ten years ago, the by-law relating to the Judicial Council was retained, and some of you have personal knowledge of the fact that a quorum at the annual meeting seldom materialized. For three years, 1904 to 1906, a certain case awaited action of the Council, and for three consecutive years a physician personally interested attended the annual sessions to appear before the Council without avail. As it seemed difficult to gather together at the annual session a quorum of the Judicial Council, the by-law was changed in 1907—this, as you know, making the Judicial Council a temporary body, to be appointed each year from the members of the House of Delegates present. The duties and powers of this body under the present by-law are so indefinitely stated that at the very next annual session the chairman of the Council informed the House of Delegates that it had nothing to report because "it is impossible for a case to reach the Judicial Council."

Thus, as a matter of fact, the Judicial Council—which should be one of the most important committees of the Association—has been a failure, and questions of great importance have not been met as they deserve. While the need of such a committee has always been evident, such need is certainly greater to-day than ever before.

Excepting one or two states, there is no control of membership by either the state or the American Medical Association. It is left absolutely with the component county society. As the latter is the portal of admission to the whole organization, the organization should have some check on who may and who may not be admitted. Complaints are made here and there of some excellent physicians who, for personal or other reasons, are kept out of the organization by the component societies. On the other hand, some component societies have admitted and retain as members those who should not be in the organization. The right of appeal, at least to the state society, should be provided for a physician who desires, but is refused, membership; the authority to see that the principles underlying membership are carried out by the county society should lie in the state and the national associations.

The questions of secret division of fees, contract practice, advertising, etc., should be met and given careful, judicious and deliberate consideration. All these, and similar matters belong to a body such as the Judicial Council is supposed to be.

I would, therefore, respectfully urge that the Judicial Council be re-created as a permanent body; that its functions should be made broader than they have been in the past; that it should be authorized to hold such meetings as it may deem necessary; that it be authorized to adopt such rules and methods of procedure as it deems best, to be approved by the House of Delegates; that the Secretary of the Association shall be, ex officio, the secretary of this Council; and that the board of trustees be requested to appropriate so much money as may be necessary to pay the expenses of the members, the last being of fundamental importance if the Council is to be a success.

"ORGANIZATION" AND THE COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

Among the functions delegated to the Council on Health and Public Instruction last year is "Organization." Organization really belongs to the Secretary's work. It would therefore seem advisable to take the word "Organization" from Section 5, Chapter 9, pp. 19 and 20.

Respectfully submitted,
GEORGE H. SIMMONS, Secretary.

Report of the Board of Trustees

Dr. M. L. Harris, Chairman, read the Report of the Board of Trustees, which was referred to the Reference Committee on Reports of Officers. It was as follows:

To the Members of the House of Delegates of the American Medical Association:

After some months of unavoidable delay due to strikes, etc., the Association was able to move into its new building about the first of the year. The building is a model of construction, being as near fireproof and as perfect in its appointments as it is possible to make it. The Association, therefore, is to be congratulated on its beautiful new home and on the unexcelled facilities which it now possesses for carrying on its work.

However, while thus felicitating ourselves on the magnificence and the excellence of our possession we should not forget that the advantages which accrue therefrom entail on us obligations of like magnitude. To fail to make proper use of the great opportunities for good which are offered us would be a most flagrant dereliction of duty.

As the Association grows in strength and influence its responsibilities increase. These responsibilities rest not alone on the officers of the Association and on the committees but also on every member of this House of Delegates. Nor do these responsibilities cease on the adjournment of the annual session.

The members of this House are representative and influential men from every state in the Union and the Association needs their help and cooperation in furthering its aims not only here during the annual session but also throughout the year in their respective localities.

The House of Delegates in meeting assembled can pass resolutions condemnatory of such practices as the division of fees or the use of the public press for self-laudatory purposes which not only derogate from the honor and dignity of the individual but degrade the profession; or it can pass resolutions commendatory of such measures as tend to elevate the educational and ethical standards of the profession; but such resolutions will be productive of little lasting good unless each delegate take it on himself to carry the intent and spirit contained therein back to his own state society and from there to the local societies and cease not his labors until they reach and are approved by every individual member throughout the land.

It is the duty of this body to consider carefully all questions which have a material bearing on the welfare of the profession and of the people along health lines and sufficient time should be devoted to them so that when the conclusions are reached they will show they are the result of mature deliberation.

In an association as large as this and extending over such a large territory it is but natural that there should be honest differences of opinion among its members and a diversity of interests due to local conditions which have a legitimate basis in fact, but these differences should not be permitted to interfere with the accomplishment of the real objects of the Association nor should they embitter anyone toward those who are conscientiously and diligently striving to obtain for all the fruition of these objects.

That the accomplishment of some of these objects would injuriously affect certain interests outside of the profession which have profited by unscrupulous practices was self-evident and it was therefore expected that their opposition, both direct and indirect, would be provoked but the antagonism of such outside interests, whether directed against the Association or against any of its representatives, is harmless and can be easily withstood.

The harmful attacks, however, are those which have their origin within the Association—harmful because an attack from within is a part arrayed against the whole and the whole must certainly suffer as a result of the unharmonious action of its parts.

A sharp distinction should be made between an attack and an expressed difference of opinion. The former is an attempt to do violence, hence is always destructive in its tendency; the latter is an attempt to bring about a favorable change by showing wherein the thing sought to be charged is wrong, hence is constructive in its tendency; the former should be crushed, the latter encouraged.

The Association to-day is confronted by several problems which undoubtedly will give rise to differences of opinion as to their best solution.

One of these problems and one, too, which is worthy of the most earnest consideration by the members of this House of

Delegates is that of membership in this Association. Shall membership in this Association be extended so as to include all those who are members in good standing in a component society? What regulations governing membership shall this Association adopt? It will be remembered that a resolution dealing with this question was introduced in the last House of Delegates and referred to the Board of Trustees with the request that the question of the extension of membership be investigated by the Board and that it report back to the House of Delegates. The Board has submitted the question to the different state associations and, while it awaits the reports from the state associations, it believes the matter should receive thorough discussion in the House of Delegates at this time.

It is not expected that definite action on the matter shall be taken at this session but the various aspects of the subject should be presented and discussed in order that the delegates may become thoroughly familiar with them and thus be able to present the matter more intelligently to their several states.

Another matter of importance is that which relates to the subscription to THE JOURNAL by members. Subscription to THE JOURNAL is now a membership requirement. This of course would have to be changed if membership is extended as above mentioned. In addition to the regular journal the association is now publishing the *Archives of Internal Medicine* and the *Journal of Diseases of Children* and will soon begin publishing the *Archives of Surgery*.

As each member now receives a copy of THE JOURNAL it necessarily happens that duplicate copies are received by firms or families having two or more members. A number of letters have been received from such members asking to be relieved from paying for the superfluous copies. At present however, there is no provision made for such cases. Therefore, in order to meet this situation the Board of Trustees recommends that the By-Laws be so amended as to permit members under those circumstances to have their subscription applied to any one or more of the periodicals above mentioned.

While on the subject of membership attention is directed to a defect in our By-Laws which consists in the omission therefrom of definite rules governing appeals by individuals or by constituent societies from decisions of local societies to a tribunal of this body for definite and final adjudication. This tribunal should constitute in a sense a supreme court which should give final judgment on all matters affecting the constitutional rights of individuals and on matters of principle affecting the interests of the association.

Conditions are constantly arising in different parts of the country which show the need of such a tribunal and also the desirability of investing it with the authority to institute investigations on its own initiative under certain regulations.

It is true the By-Laws now provide for a Judicial Council, but it is not of a permanent character, has no initiative power and its functions are very indefinitely defined. The Board of Trustees, therefore, recommends that the By-Laws be amended to meet the defects mentioned.

ARCHIVES OF INTERNAL MEDICINE

No particular effort has been made during the past year to increase the circulation of the *Archives of Internal Medicine*, but it is very satisfactory. On Jan. 1, 1911, the circulation was 2,133, which shows a slight increase over last year.

Considering the fact that this journal is more technical than of practical value to the general practitioner, this circulation may be regarded as unusually good.

AMERICAN JOURNAL OF DISEASES OF CHILDREN

The first number of the *American Journal of Diseases of Children* was issued in January, 1911. On June 1 the paid circulation was over sixteen hundred—a remarkable showing for a special journal.

The Association button which was adopted by the House of Delegates last year on the recommendation of the committee which had the matter in charge, while very handsome and appropriate from the designer's standpoint, has been found to be impractical from the manufacturer's standpoint. It is therefore referred back to this body for reconsideration to see if a design can be presented which will meet the requirements of economical manufacture.

As has been customary in the past, there will be found appended to this report a complete and comprehensive statement by the auditors showing the financial status of the association for the year ending December 31, 1910.

Respectfully submitted,

PHILIP MILLS JONES,
W. T. SARLES,
C. A. DAUGHERTY,
W. T. COUNCILMAN,
W. W. GRANT,
FRANK J. LUTZ,
C. E. CANTRELL,
WISNER R. TOWNSEND, Secretary.
M. L. HARRIS, Chairman.

Addenda to Trustees' Report

SUBSCRIPTION DEPARTMENT

The regular weekly issue of THE JOURNAL of the American Medical Association, from Jan. 1, 1910 to Dec. 31, 1910 inclusive, fifty-three issues, was as follows:

January 1	58,254		May 7	60,126	
January 8	55,942		May 14	55,133	
January 15	55,641		May 21	55,164	
January 22	55,176		May 28	55,966	
January 29	55,035				226,389
		280,048	June 4	55,510	
February 5	54,848		June 11	55,302	
February 12	57,023		June 18	55,308	
February 19	56,993		June 25	55,320	
February 26	57,109				221,440
		225,973	July 2	55,555	
March 5	57,143		July 9	55,644	
March 12	57,213		July 16	55,284	
March 19	57,027		July 23	55,621	
March 26	57,317		July 30	55,445	
		228,700			277,549
April 2	57,372		August 6	55,653	
April 9	57,771		August 13	55,679	
April 16	57,279		August 20	55,619	
April 23	57,251		August 27	55,732	
April 30	55,036				222,683
		284,909			
September 3	55,888		November 5	57,260	
September 10	55,799		November 12	57,223	
September 17	55,750		November 19	57,109	
September 24	55,784		November 26	57,236	
		223,207			228,828
October 1	55,542		December 3	59,131	
October 8	55,966		December 10	59,321	
October 15	55,975		December 17	58,581	
October 22	57,019		December 24	58,663	
October 29	57,018		December 31	58,684	
		281,520			294,480
Total issue for twelve months					2,995,726
Weekly average					56,523

The total number of copies issued during 1909 was 2,878,799; thus there was an increase during the year of 116,927 copies.

Percentage of Physicians Receiving The Journal

This table gives the number of physicians (based on the second edition of the American Medical Directory) in the United States, receiving THE JOURNAL and the approximate percentage in each state. Copies to physicians in the United States Army, United States Navy, Marine-Hospital Service, etc., are omitted:

State.	Number Receiving JOURNAL.	Physicians in State 2d A. M. A. Dir.	Approx. per cent. 2d A. M. A. Dir.
Alabama	642	2,287	28.
Arizona	140	246	56.9
Arkansas	611	2,535	24.1
California	2,014	4,313	46.6
Colorado	787	1,690	46.5
Connecticut	634	1,424	44.5
Delaware	84	220	38.1
District of Columbia	528	1,231	42.9
Florida	341	786	43.3
Georgia	742	2,887	25.7
Idaho	179	343	52.1
Illinois	5,047	9,744	51.7
Indiana	1,822	5,306	34.3
Iowa	1,760	3,624	48.5
Kansas	1,290	2,650	48.6
Kentucky	1,090	3,708	29.3
Louisiana	757	1,798	42.1
Maine	390	1,198	32.5
Maryland	1,037	2,012	51.5
Massachusetts	2,357	5,577	42.2
Michigan	1,667	4,109	40.5
Minnesota	1,330	2,204	60.3

Mississippi	464	2,054	22.5
Missouri	2,446	6,332	38.6
Montana	229	417	54.9
Nebraska	779	1,776	43.9
Nevada	82	177	46.3
New Hampshire	285	679	41.9
New Jersey	1,160	2,455	47.2
New Mexico	173	367	47.1
New York	4,888	14,117	34.4
North Carolina	550	1,761	31.2
North Dakota	344	552	62.3
Ohio	2,877	7,838	36.9
Oklahoma	716	2,703	26.4
Oregon	398	782	50.8
Pennsylvania	4,478	11,056	40.5
Rhode Island	326	720	45.2
South Carolina	431	1,141	37.7
South Dakota	350	607	57.6
Tennessee	814	3,303	24.6
Texas	1,658	5,789	28.6
Utah	240	359	67.1
Vermont	222	663	33.4
Virginia	833	2,215	37.6
Washington	843	1,404	60.0
West Virginia	614	1,608	38.1
Wisconsin	1,366	2,518	54.2
Wyoming	101	202	50.

The following table shows the number of Members and Subscribers for each year, commencing with 1900:

	Members	Subscribers
January 1, 1900	8,445	4,633
January 1, 1901	9,841	8,339
January 1, 1902	11,107	10,795
January 1, 1903	12,553	12,378
January 1, 1904	13,899	14,674
January 1, 1905	17,570	15,698
January 1, 1906	20,826	17,669
January 1, 1907	26,255	20,166
January 1, 1908	29,382	20,880
January 1, 1909	31,999	18,983
January 1, 1910	33,032	19,832
January 1, 1911	33,540	20,504

The above does not include the ex-officio members, as, for instance, the officers of the Medical Department of the Army and the Navy, and the Marine-Hospital Service, since THE JOURNAL does not go to them as individuals. Neither does it include honorary members, exchanges, complimentary copies to libraries, agents, advertisers, etc.

On January 1, 1910, there were 53,729 names on the mailing list and on January 1, 1911, 54,957, showing an increase in the mailing list for the year of 1,228. However, 11,706 additional names were placed on the mailing list, and 10,276 were discontinued on account of death, ineligibility to membership, resignations, non-payment of dues, subscriptions and voluntary discontinuances.

Treasurer's Report

REPORT OF THE TREASURER OF THE AMERICAN MEDICAL ASSOCIATION FOR THE YEAR ENDING DEC. 31, 1910

IN FIRST TRUST AND SAVINGS BANK

RECEIPTS

Jan. 1, 1910—Certificates of deposit at 3 per cent.	$100,000.00	
Feb. 10, 1910—Received from the Editor and General Manager, and placed on certificate deposit, 3 per cent	40,000.00	
May 11, 1910—Received from the Editor and General Manager, and placed on certificate deposit, 3 per cent	30,000.00	
		$170,000.00

DISBURSEMENTS

Jan. 17, 1910—Transferred to First National Bank, checking department	$ 45,000.00	
Oct. 10, 1910—Transferred to First National Bank, checking department	45,000.00	
Dec. 10, 1910—Transferred to First National Bank, checking department	15,000.00	
Dec. 17, 1910—Transferred to First National Bank, checking department	25,000.00	
Dec. 31, 1910—Certificate of deposit in First Trust and Savings Bank, date Dec. 9, 1910	40,000.00	
		170,000.00

IN FIRST NATIONAL BANK

RECEIPTS

Jan. 1, 1910—Balance in First National Bank	$ 8,340.72	
Interest on checking account, 12 months	149.00	
Interest on certificates of deposit First Trust and Savings Bank	4,218.75	
June 17, 1910—Transferred from First Trust and Savings Bank	45,000.00	
Oct. 10, 1910—Transferred from First Trust and Savings Bank	45,000.00	
Dec. 10, 1910—Transferred from First Trust and Savings Bank	15,000.00	
Dec. 17, 1910—Transferred from First Trust and Savings Bank	25,000.00	
Interest on 54 $1,000 bonds at 4 per cent	2,160.00	
		144,868.47

DISBURSEMENTS

June 17, 1910—Paid requisition Building Account	$ 50,000.00
Oct. 10, 1910—Paid requisition Building Account	50,000.00
Dec. 12, 1910—Paid requisition Building Account	20,000.00
Dec. 31, 1910—Balance in First Nat'l Bank	24,868.47
	144,868.47

DEC. 31, 1910, PROPERTY OF AMERICAN MEDICAL ASSOCIATION IN HANDS OF TREASURER

Cash balance in checking account First National Bank		$ 24,868.47
Certificate of Deposit at 3 per cent. in First Trust and Savings Bank		40,000.00
Bonds in care First Trust and Savings Bank		

	Cost.	Par Value.	
5–1000 bonds U. P. Ry., 1st 4s	$ 5,207.50	$ 5,000.00	
5–1000 bonds Erie Ry., 1st 4s	4,932.50	5,000.00	
10–1000 bonds Reading Cen. 1st 4s	9,602.50	10,000.00	
14–1000 bonds Chicago Sch. 1st 4s	15,168.13	14,000.00	
10–1000 bonds A. T. & S. F. 1st 4s	9,521.25	10,000.00	
10–1000 bonds B. & O. Ry. 1st 4s	9,800.00	10,000.00	
	$54,231.88	$54,000.00	54,000.00
			$118,868.47

Respectfully submitted,
FRANK BILLINGS, Treasurer.

Auditor's Report

MARWICK, MITCHELL & CO., CHARTERED ACCOUNTANTS
79 WALL STREET

NEW YORK, Jan. 31, 1911.

To the Board of Trustees of the
American Medical Association, Chicago, Ill.

Dear Sirs:

In accordance with your instructions, we have audited the accounts of the American Medical Association for the year ended Dec. 31, 1910, on which we now submit our report, together with the statements detailed in the index appended hereto.

We examined the securities representing the investments of the Association and counted the cash on hand. The cash in banks was verified by certificates from the bankers.

The disbursements were vouched and found in order and a satisfactory test of the revenue of the Association was made.

The balance sheet now submitted is, in our opinion, a full and fair statement of the financial position of the Association as at Dec. 31, 1910, and as shown by the books; subject to the qualification that no provision has been set aside for accrued taxes, and subscriptions and memberships paid in advance, which are partially offset by unpaid subscriptions and memberships, earned but not included in the accounts.

The following is a comparative condensed balance sheet as at Dec. 31, 1910 and 1909:

Assets:	DECEMBER 31 1910	1909	INCREASE	DECREASE
Property and Plant	$288,833.66	$173,081.86	$115,751.80	
Biographical Information	1,546.83		1,546.83	
Investments	94,231.88	154,231.88		$60,000.00
Current and Working	64,948.87	71,688.31		6,739.44
Prepaid Accounts	1,072.32	460.11	612.21	
Total Assets	$450,633.56	$399,462.16	$ 51,171.40	
Liabilities	2,104.18	2,926.95		$ 822.77
Surplus	$448,529.38	$396,535.21	$ 51,994.17	

The increase in surplus, $51,994.17, represents the net income for the year under review, particulars of which are recorded in Exhibit "B."

During the year under review depreciation aggregating $47,306.83 has been written off the property accounts. Of this, $16,292.66 applies upon the new buildings and the machinery, plant, etc., while the remainder, $31,014.17, is upon the old building, which is not now used in connection with the operation of the business. After the application of this latter sum the old building, including the site, appears in the accounts at $42,000.00.

We are pleased to report that the records of the Association are maintained in a careful and efficient manner.

We desire to record our appreciation of the courtesies extended to us during the course of our examination. Yours truly,

MARWICK, MITCHELL & CO., Chartered Accountants.

EXHIBIT "A"

BALANCE SHEET AS AT DEC. 31, 1910

ASSETS

Property and Plant:		
Real Estate and Buildings		$226,657.65
Machinery		38,822.55
Type and Metal		11,179.31
Furniture and Fixtures		8,477.68
Laboratory		1,015.60
Stereotype Plant		1,495.26
Library		1,185.61
Total Property and Plant		$288,833.66
Biographical Information		1,546.83
Investments:		
Bonds at Cost (Schedule "1")	$54,231.88	
Certificates of Deposit	40,000.00	
Total Investments		94,231.88

Current and Working Assets:			
Material and Supplies as per Inventory		8,289.04	
Accounts Receivable:			
Advertising	$19,794.02		
Books	1,199.00		
Reprints	893.10		
Directory	130.95		
Jobbing and Miscellaneous	2,547.10		
		24,564.17	
Bills Receivable		132.65	
Cash in Banks and on Hand:			
The First National Bank of Chicago	$24,868.47		
Continental and Commercial National Bank of Chicago	4,944.52		
Cash on Hand	2,100.02		
Office Fund	50.00		
		31,963.01	
Total Current and Working Assets			64,948.87
Prepaid Accounts:			
Insurance	$ 247.77		
Unissued Publications	700.17		
Los Angeles 1911 Session	124.38		
Total Prepaid Accounts			1,072.32
Total			$450,633.56

LIABILITIES

Miscellaneous Accounts Payable	$	132.78
Advance Payments on Publications		1,971.40
Surplus:		
As at Dec. 31, 1909	$396,535.21	
Net Income for Year ended Dec. 31, 1910	51,994.17	
		448,529.38
Total		$450,633.56

EXHIBIT "B"

INCOME ACCOUNT FOR THE YEAR ENDED DEC. 31, 1910

Revenue:		
Membership Dues	$	51,597 38
Journal Subscriptions		207,974.45
Journal Advertising		164,492.72
St. Louis Session		11,304.15
Jobbing		4,750.52
Books		2,531.33
Reprints		2,487.07
Physicians' Manual		764.42
New and Nonofficial Remedies		317.62
Buttons		294.92
Binders		175.60
Waste Paper, etc.		3,652 57
Total		$450,342.75
Less Archives of Internal Medicine		37.28
Gross Revenue		$450,305.47
Expenses:		
General and Operating Expenses (Schedule "2")	$302,279.94	
St. Louis Session	11,968.89	
Provision for Depreciation (Schedule "3")	16,292.66	
		330,541.49
Net Revenue		$119,763 98
Other Income:		
Interest:		
On Bonds	$ 2,160.00	
On Treasurer's Account	4,367.75	
On Bank Balance	1,076.56	
	$ 7,604.31	
Loss on Bad and Doubtful Accounts and Notes less Recoveries	1,071.22	
		6,533.09
Gross Income		$126,297.07
Deductions from Income:		
Association Expenditures (Schedule "4")	$ 40,350.34	
Second Edition Directory	2,938.39	
Depreciation on old Building not now used in operations of business	31,014.17	
		74,302.90
Net Income		$ 51,994.17

SCHEDULE "1"

BONDS AS AT DEC. 31, 1910

No.	DESCRIPTION AND PARTICULARS	PAR VALUE	COST
5	Atchison, Topeka & Santa Fe Ry. Co. 4 per cent. 100-year gold bonds	$ 5,000.00	$ 4,988.75
5	Erie Railroad Co. 4 per cent. 100-year gold bonds	5,000.00	4,932.50
5	Baltimore & Ohio Ry. Co. 4 per cent. first mortgage	5,000.00	5,032 50
5	Reading Company 4 per cent. general mortgage	5,000.00	4,870 00
5	Union Pacific Railroad Co. 4 per cent. first mortgage	5,000.00	5,207.50
14	City of Chicago 4 per cent. school bonds	14,000.00	15,168.13
5	Reading Co. and the Philadelphia & Reading Coal and Iron Co. 4 per cent. general mortgage, par value $1,000.00 each, at 94½	5,000.00	4,732.50
5	Atchison, Topeka & Santa Fe Ry Co. 4 per cent. first mortgage bonds, payable April and October, principal due 1995, Nos. 32785, 35162, 40517, 40516 and 40515, par value $1,000.00 each, at 90¼	5,000.00	4,532.50
5	Baltimore & Ohio Ry. Co. 4 per cent. first mortgage bonds, payable April and October, principal due 1948, Nos. 53591, 53594, 53593, 34986 and 34987, par value $1,000.00 each, at 95	5,000.00	4,767.50
	Total	$54,000.00	$54,231.88

SCHEDULE "2"

GENERAL AND OPERATING EXPENSES FOR THE YEAR ENDED DEC. 31, 1910

Pay-roll		$120,172.98
Materials and Supplies:		
Paper	$ 87,778.94	
Ink	3,253.14	
Electrotypes	3,070.81	
Binding	141.25	
Miscellaneous Supplies	4,979.68	
		99,223.82
Editorials, News and Reporting		8,851.05
Postage:		
Second Class	$ 22,130.16	
General	10,825.13	
		32,955.29
Commissions:		
JOURNAL	$ 8,502.33	
Buttons	265.09	
Collection Commission	2,900.34	
		11,667 76
Plant:		
Repairs and Renewals	$ 2,077.54	
Power	2,293.31	
Light	2,954.73	
Fuel	1,116.54	
Building Maintenance	236.22	
Supplies	2,576.27	
		11,254.61
Insurance and Taxes		2,956.83
Discount		4,364.62
Express and Cartage		1,619.54
Agents' Salaries		890.00
Exchange		1,228.65
Legal		983.52
Office Printing and Stationery		1,951.37
Office Supplies		592.26
Telephone and Telegraph		340.23
JOURNALS Returned		43.65
Traveling Expenses		392.65
Complimentary Reprints		192.65
Miscellaneous		2,558.46
Total		$302,279.94

SCHEDULE "3"

PROVISION FOR DEPRECIATION FOR THE YEAR ENDED DEC. 31, 1910

Classification	*Amount*
Building—New	$ 10,000.00
Machinery	4,313.62
Furniture and Fixtures	663.45
Type	427.98
Metal	380.55
Factory Fixtures	228.24
Stereotype Plant	166.14
Laboratory Equipment	112.68
Total	$ 16,292.66

SCHEDULE "4"

ASSOCIATION EXPENDITURES FOR THE YEAR ENDED DEC. 31, 1910

Association	$ 9,970.32
Organization	7,882.30
Medical Education	5,194.37
Medical Legislation	2,799.05
Pharmacy and Chemistry	8,756.32
Health and Public Instruction	3,220.64
Educational	1,796.45
Defense of Medical Research	730.89
Total	$ 40,350.34

Report of the Council on Health and Public Instruction

Dr. Henry B. Favill, Chicago, Chairman, read the report of the Council on Health and Public Instruction, which was referred to the Reference Committee on Medical Legislation. The report was as follows, including all the subcommittees of the Council:

To the Members of the House of Delegates of the American Medical Association:

This Council was created at the 1910 session, as the result of the report of a committee appointed at the 1909 session at Atlantic City. The standing Committee on Medical Legis-

lation, the Board of Public Instruction on Medical Subjects, the Council on Defense of Medical Research and the Committee on Organization were merged in this council, to which was added the Committee on Uniform Regulation of Membership, the Committee on Visual Standards of Pilots, the Public Health Education Committee, the Committee on Prevention of Blindness and the Committee on Postgraduate Study Work. The first meeting of the Council was held in Chicago Friday, July 8, 1910, and the term of service of the members was determined by lot as follows: Dr. Henry B. Favill to serve until 1911; Dr. W. B. Cannon, 1912; Dr. J. N. McCormack, 1913; Dr. Henry M. Bracken, 1914; Dr. W. C. Woodward, 1915. Dr. Henry B. Favill was elected chairman and Dr. Frederick R. Green was nominated to the trustees as secretary, which nomination was confirmed by the Board of Trustees. The following bureaus were established, with one member of the council in charge of each: Legislation, Dr. W. C. Woodward; Organization, Dr. J. N. McCormack; Publicity, Dr. Henry B. Favill; Protection of Medical Research, Dr. W. B. Cannon; Public Health, Dr. H. M. Bracken. Inauguration of the work of the Council was necessarily deferred until after the October meeting of the Board of Trustees, October 21, at which time an appropriation was made for the use of the Council. This report, therefore, really covers only the seven months from Nov. 1, 1910, to June 1, 1911.

The work of the Council will be taken up under the following heads: (A) Work of the various bureaus subordinate to the Council; (B) Work of the various sub-committees subordinate to the Council.

A. WORK OF THE COUNCIL AND ITS BUREAUS

(1) BUREAU OF ORGANIZATION

The organization work of the Council has been, as heretofore, in charge of Dr. J. N. McCormack. During the past year, Dr. McCormack has held meetings and delivered public addresses as follows: October 3-31, Oklahoma. Public meetings were held in twenty-nine cities of the state at which Dr. McCormack delivered an address on public health. Meetings of the county medical society were also held in each city which Dr. McCormack visited, at which meetings he talked to the local medical profession on medical organization. New Mexico, November 2-13. Addresses were made to the public and the profession in eight cities. From November 14 to 28, ten meetings were held in Arizona. December and January were passed in Washington. On January 21, Dr. McCormack began a series of meetings in North Carolina, speaking at ten cities in the state. February 12-26 was devoted to Georgia, fourteen meetings being held; from April 24 to May 10, ten meetings were held in South Carolina. On May 11, Dr. McCormack attended the annual meeting of the Florida State Medical Association and delivered a public address at Tallahassee. On May 16, he addressed a large meeting in Buffalo, May 17, Niagara Falls, May 18, Albany, May 22, Bridgeport, Conn., and May 24, Winchester, Va. On June 10, he began a tour of Texas, speaking at ten cities from June 10 to 21. During the year Dr. McCormack has visited ninety-seven cities in eleven states and has delivered addresses in each.

The great value of Dr. McCormack's work as a means of instructing and enlightening both the profession and the public is too well known to require comment. Careful preparation for these meetings were made beforehand in accordance with the plan followed for the past five years, and in practically all instances large and enthusiastic audiences, composed of representative citizens of the community, have benefited by Dr. McCormack's work. The value of these meetings in educating public sentiment is becoming every year more apparent. The attitude of the public is shown not only by the large attendance but also by the appreciative newspaper comments and editorials which have appeared in the local press. It is also noticeable that the public support and the newspaper commendation given to Dr. McCormack's work has been greater in those states in which he has spoken a second time than in those in which he has made his first appearance. The public is eager to be enlightened on sanitary and public health matters and is showing increased appreciation of the efforts of the Association in this direction. The Council is considering the advisability of putting a number of speakers in the field, as the work to be done is far too great for the strength of one man.

(2) BUREAU ON PROTECTION OF MEDICAL RESEARCH

The Bureau for the Protection of Medical Research has continued the publication of articles and pamphlets, written by authorities, and giving reliable information about animal experiments. During the past year the following pamphlets, in addition to the thirteen previously reported, have been published:

Animal Experimentation in Relation to Practical Medical Knowledge of the Circulation. Joseph Erlanger.
The Relation of Animal Experimentation to Our Knowledge of Plague. George W. McCoy.
Medical Control of Vivisection. Walter B. Cannon.
Immunology: A Medical Science Developed Through Animal Experimentation. Frederick P. Gay.
Obstetrics and Animal Experimentation. J. Whitridge Williams.
Some Characteristics of Antivivisection Literature. Walter B. Cannon.
Animal Experimentation in Relation to Epidemic Cerebrospinal Meningitis. Charles Hunter Dunn.
The Value of Animal Experimentation as Illustrated by Recent Advances in the Study of Syphilis. John W. Churchmann.

There has been a considerable demand for these and for previously published numbers of the series, so that reprinting some of the pamphlets has been necessary.

By diffusing literature, by speaking at public meetings, and by appearing at legislative hearings, members of the bureau have helped toward a better understanding of the methods and purposes of animal experimentation and have resisted attempts to secure hostile legislation. The only states in which serious efforts were made this year to enact bills opposing laboratory investigation were Pennsylvania and New York.

The plan of the bureau to control laboratory procedures, in a manner satisfactory to reasonable people, by regulations adopted by the corporate bodies which include the laboratory workers, has been given wide publicity during the year. Favorable comment on the precautions thus taken to prevent unnecessary discomfort in animals used for experimentation has been made both in the daily press and in influential weekly publications.

The plans for the establishment of a society of laymen for the promotion of medical research, mentioned a year ago, have not gone further, though an attempt may be made during the next few months to form such an organization.

A large number of copies of the twenty pamphlets prepared by the Bureau for public distribution have been circulated. Copies have been sent to members of legislative committees for distribution to members of state legislatures, as well as to several educational institutions for distribution to students.

(3) BUREAU ON MEDICAL LEGISLATION

When the annual convention of the Association adjourned at St. Louis, in June last, it was hoped that before Congress met in the following December the special committee created by the Association for that purpose might have formulated a bill for the organization of the federal health services that would receive the unqualified support of all persons interested in the conservation and improvement of the public health. The organization of that special committee was, however, delayed, and whatever it has done with respect to federal sanitary organization the Council has been compelled to do without the advantage of such light as that committee's labors might have thrown on the subject. The Sixty-First Congress adjourned without anything having been accomplished, but fortunately no obstructive legislation was enacted. On the opening of the Sixty-Second Congress, the very first bill to obtain a place on the Senate Calendar was A Bill To Establish a Department of Health, and for other purposes, which was introduced by Senator Owen. As, however, Congress, in special session now in progress, is not taking up any general legislation except that for the consideration of which the session was convened, no action has yet been taken with respect to this bill except to refer it to the proper committee. The Council deems it proper here to call attention to the debt which the medical profession and the public owes to Senator Owen for his efforts on behalf of an improved federal health organization. Not only has he identified himself with all efforts that have been made to improve that branch of the federal government, taking the initiative himself whenever that seemed to be the most effective way of proceeding, but it was through his initiative and effort that the Senate provided increased compensation for the commissioned officers in the existing Public Health and Marine-Hospital Service. Unfortunately, however this measure failed in the House of Representatives.

State Legislation

During the past winter the legislature has been in session in thirty-six states. A large number of bills were introduced dealing with public health, vital statistics, the regulation of the practice of medicine and the establishment of sectarian boards. The following summary only includes the more important measures adopted or defeated:

ALABAMA:—The medical practice act was amended making it unlawful for physicians to advertise so as to mislead the public.

ARKANSAS:—The public health bill, prepared by the Arkansas Medical Society establishing a state department of health, has become a law. The model vital statistics bill of the American Medical Association was incorporated in this bill. A bill was also passed to consolidate the medical college of the University of Arkansas and the College of Physicians and Surgeons and turn these two schools over to the board of trustees of the State University.

CONNECTICUT:—Two optometry bills and an antivivisection bill failed to pass.

ILLINOIS:—A bill to abolish common drinking-cups and a bill to amend the medical practice act became laws. The vital statistics bill failed to pass. A number of optometry and osteopathic bills also failed to pass.

IOWA:—Bills to make appropriations for free distribution of antitoxin and for vital statistics, to authorize the sterilization of criminals and to require the disinfection of premises occupied by tuberculous patients became laws. The osteopathic bill and the bill to reorganize the state board of health were defeated.

KANSAS:—The model vital statistics bill become a law.

MAINE:—A revised medical practice act was passed and an osteopathic bill was defeated.

MICHIGAN:—A bill to require the recording of all cases of tuberculosis and a Sane Fourth of July bill became laws. A chiropractic bill was defeated.

MISSOURI:—An optometry bill was defeated.

NEBRASKA:—A number of bills to make liberal appropriations for state institutions were passed.

NEW HAMPSHIRE:—A bill to consolidate the three existing medical boards failed to pass, also an osteopathic bill. The optometry bill and a bill to abolish the common drinking cup became laws.

NORTH DAKOTA:—A new medical practice act was passed.

OKLAHOMA:—An optometry bill was passed.

PENNSYLVANIA:—An optometry bill was defeated and a bill to provide for a single board of medical examiners is still under consideration.

TEXAS:—The sanitary code drafted by the state board of health and incorporating the model vital statistics' bill was enacted as a part of the statutes.

UTAH:—A new medical practice act was passed, also a bill to require the reporting of all cases of ophthalmia neonatorum.

The Council, through its Bureau of Medical Legislation, has cooperated with the state legislative committees, sending them information and material whenever requested. Particularly valuable in this work has been the special optometry number of the bulletin prepared by a committee consisting of Drs. J. C. Bossidy, George W. Gay and James Thorington. This bulletin was issued under date of Nov. 15, 1910, and large quantities of it were distributed to members of committees in states in which optometry bills were introduced.

At the request of the Council, the attorneys for the Association have prepared an exhaustive brief on "Chiropractic," which was prepared originally for the assistance of the secretary of the Michigan State Board of Medical Examination and Registration. This brief contains a carefully considered legal argument based on supreme court decisions, to the effect that Chiropractic is the practice of medicine and that the followers of this cult are amenable to the medical practice laws. Copies of this pamphlet have been sent to the secretaries of all state examining boards and in a number of instances to the counsel of the board as well.

The compilation and abstracting of supreme court decisions on medical practice acts has been practically completed and the matter is now in the hands of the printer. It is hoped that in a short time a digest of over three hundred supreme court decisions can be issued for the guidance and assistance of the officers of medical examining and licensing boards. As soon as this volume is completed it is the intention of the secretary to prepare a similar volume on supreme court decisions on public health laws. Such a work is badly needed and will be of great assistance to state and municipal health officers.

The organization of the National Legislative Council and of the National Auxiliary Legislative Committee has been maintained and the bureau has been in constant communication with members of these two bodies in the different states.

On February 28 and March 1 and 2, the Annual Conference on Medical Legislation was held in conjunction with the Council on Medical Education. The first day of the session was devoted to medical education, the second day to a joint conference on state regulation of the practice of medicine and the third day to the annual meeting of the National Legislative Council. The attendance at this joint conference was gratifying, 158 being registered as in attendance.

(4) BUREAU ON PUBLIC HEALTH

While all the work of the Council has been indirectly of value to public health, no new work in this direction has been taken up as yet.

(5) BUREAU ON PUBLIC INSTRUCTION

Probably the most important new line of work taken up by the Council has been the preparation and distribution of regular bulletins to the newspapers of the country on public health matters. A selected mailing list has been compiled, composed of (a) daily newspapers having a circulation of 3,000 or over—888; (b) daily newspapers having a circulation of under 3,000—1,230; (c) selected weekly newspapers in counties in which no daily is published—1929; (d) religious—127; (e) agricultural—229; (f) educational—73; (g) labor—218; (h) fraternal—87; (i) miscellaneous—37; total—4,818. Since the first of January regular weekly bulletins have been sent out, comprising originally the first list compiled, viz., that of dailies of over 3,000 circulation and later of both the lists of dailies as well as occasional bulletins to selected class publications. Previous to the first of January a number of bulletins were sent out, as experiments, on the following topics: "Typhoid Fever in Milwaukee," "Vital Statistics a Business Asset," "Fourth of July Injuries" (an abstract of the eighth annual summary of Fourth of July injuries reported in THE JOURNAL for Sept. 3, 1910, as well as a reprint of the entire article, the latter bulletin being given wide circulation). An idea of the scope of the work since the first of January can be gained from the following titles of bulletins sent out:

January 6—Typhoid Fever in Des Moines.

January 13—Consumption-Cure Fakes.

February 3—Prevention of Fourth of July Tetanus; Nature's Creation, a Consumption-Cure Fraud.

February 10—Need of Caution in the Use of Salvarsan; Advertising Salvarsan to the Public; The Truth About "606."

February 25—Weak Medical Schools as Nurseries of Medical Genius.

March 24—Occupational Diseases; Professor Vincent and Higher Educational Standards; Vaccination and Small-Pox in Japan; Announcement of the Prize Cartoon Contest.

April 1—Compressed-Air Illness and Its Prevention; Sex Instruction in the Schools; Hygiene in the Army on the Border; Proportion of Physicians to Population in the United States.

April 8—White Phosphorus; State Responsibility in Medical Education; Vaccination in the Philippines; Governor Osborn for Honest Advertising; Ministers Demand More Rigid Laws; A German View of American Medical Schools.

April 15—Individual Liberty and the Public Welfare: Sociology in Medicine; Factors in Railway Accidents; Commercial Untruthfulness; Animal Experimentation by Clergyman Scientist; Uniformity in Death Certificates; The Reformed Almanac as a Health Evangelist.

April 21—Some Problems of School Inspection; Money for Medical Education; A New Owen Bill; Applied Ethics in Journalism; Founded on Falsehood. (A comment on a case before the United States Supreme Court involving the National Food and Drugs Act.)

April 28—Lead Poisoning in Illinois (an article based on the work of the Illinois Commission on Occupational Diseases. This bulletin was sent to all the labor journals of the country).

April 28—Public Health Personnel Bills; Self-Supporting Cripples; Universities as Object Lessons in Hygiene.

May 12—President Taft's Message to Physicians; Life-Saving Abroad and Life-Wasting at Home; Public Hygiene and Private Practice; The President Versus *Life;* Human Fallibility; Child Welfare Exhibits; Saccharin, an Adulterant.

May 12—Man Suffering from Glanders Recovers; The Rockefeller Commission for the Eradication of Hookworm Disease.

May 19—The Wisconsin Pure Food Law Not Emasculated; The Use of Orange-Red Underclothing in the Tropics; The Problem of Pure Milk; Making Room for City Parks; Free Dispensaries for Hookworm Disease.

May 19—Benzoate of Soda Forbidden in Prussia; Magic Foot Drafts, a Fake; Tucker's Asthma Specific a Dangerous Cocain Mixture.

May 26—State Medical Examining Board Examinations in 1910 (a summary of the Annual State Board Number of THE JOURNAL,

containing the statistics compiled by the Council on Medical Education and a classified list of colleges arranged according to percentage of failures); The Opium Problem, Oriental and Occidental; The Plague; To Save the Babies; Progressive Medical Legislation; Nostrum Promoting as Short-Story Material; Mud Therapy; The Educational Function of Hospitals; A Good Doctor.

The most gratifying feature of the Press Bulletin service has been the readiness with which newspaper editors have utilized the material sent them. There has been a marked increase in the number of newspapers using such matter, even in the five months that the Press Bureau has been in operation. Appreciative and encouraging letters received from many editors indicate that the time is ripe for such a movement.

The question of preparing short articles on public and personal health matters, for distribution to newspapers, is also under consideration. There are a number of practical difficulties to overcome, but it is hoped that plans can be devised during the coming year by which the press of the country can be supplied with sound, up-to-date scientific matter on hygiene, prepared for popular understanding.

COOPERATION WITH STATE BOARDS OF HEALTH

It seemed obvious to the Council that in inaugurating plans for public education it should carefully avoid encroaching on fields already occupied by existing health agencies, either state, municipal or philanthropic, and that its work should rather consist of developing new fields and cooperating with and coordinating existing health agencies. One of the most common and effective methods of public education is the distribution of pamphlets containing matter adapted for popular comprehension regarding disease and its prevention. In order to ascertain exactly what was being done in this direction by state boards of health a circular letter and a blank form was sent to each state board secretary on April 26, asking for information regarding the number of pamphlets published by the board and the number of each distributed to the public. Replies received from all except Florida, Georgia and South Dakota show that thirty-four state boards are distributing material in some form to the public and that many boards are sending out large quantities of pamphlets on many subjects. A summary of the reports received follows:

PUBLIC EDUCATION PAMPHLETS ISSUED BY STATE BOARDS, ARRANGED BY STATES

ALABAMA.—No pamphlets issued at present.

ARIZONA.—No pamphlets issued.

ARKANSAS.—Board just reorganized; no pamphlets issued.

CALIFORNIA.—Tuberculosis, meningitis, care of infants, small-pox, vaccination, malaria, diphtheria, pure food, flies, hookworm, scarlet fever, measles, sex hygiene, poliomyelitis, ophthalmia neonatorum, common drinking cup, adenoids, school hygiene, whooping-cough, pneumonia, cancer, bubonic plague, municipal problems, sewage disposal, tropical diseases.

COLORADO.—No pamphlets issued.

CONNECTICUT.—Circulars and bulletins issued, subject not specified.

DELAWARE.—No pamphlets issued.

DISTRICT OF COLUMBIA.—Tuberculosis, flies.

FLORIDA.—No report.

GEORGIA.—No report.

IDAHO.—Tuberculosis, flies, measles, poliomyelitis, whooping-cough, typhoid, sanitary privies.

ILLINOIS.—Tuberculosis, care of infants, small-pox, vaccination, diphtheria, flies, scarlet fever, measles, poliomyelitis.

INDIANA.—Tuberculosis, care of infants, small-pox, vaccination, diphtheria, pure food, flies, scarlet fever, measles, sex hygiene, poliomyelitis, ophthalmia neonatorum, common drinking cup, adenoids, school hygiene, whooping-cough, pneumonia.

IOWA.—Tuberculosis, care of infants, small-pox, vaccination, diphtheria, pure food, flies, scarlet fever, poliomyelitis, common drinking cup, pneumonia, typhoid, pollution of streams, pure milk, tuberculosis among dairy herds, sanitary bakeries, cats as carriers of disease, two-wheeled push carts.

KANSAS.—Tuberculosis, care of infants, vaccination, diphtheria, pure food, flies, scarlet fever, measles, poliomyelitis, ophthalmia neonatorum, common drinking cup, whooping-cough, typhoid, pure drugs, water and sewage.

KENTUCKY.—Tuberculosis, small-pox, diphtheria, scarlet fever, ophthalmia neonatorum, typhoid.

LOUISIANA.—Tuberculosis, care of infants, vaccination, pure food, flies, hookworm, common drinking cup, adenoids, school hygiene, care of teeth, sanitary privies, sanitation of buildings (6) disinfectants, dairies, habit-forming drugs, health hints, condensed milk.

MAINE.—Pamphlets, subjects not specified.

MARYLAND.—Tuberculosis, care of infants, vaccination, malaria, diphtheria, pure food, flies, scarlet fever, measles, sex hygiene, poliomyelitis, ophthalmia neonatorum, whooping-cough, pneumonia, typhoid.

MASSACHUSETTS.—Tuberculosis, poliomyelitis, ophthalmia neonatorum, common drinking cup.

MICHIGAN.—Tuberculosis, meningitis, care of infants, small-pox, vaccination, diphtheria, pure food, scarlet fever, measles, common drinking cup, adenoids, school hygiene, whooping-cough, pneumonia, cancer, typhoid, resort sanitation, rabies, spitting, tetanus, treatment of the drowned.

MINNESOTA.—Tuberculosis, small-pox, vaccination, diphtheria, flies, hookworm, scarlet fever, measles, municipal lodging houses.

MISSOURI.—No pamphlets issued.

MONTANA.—Tuberculosis, small-pox, vaccination, diphtheria, flies, scarlet fever.

NEBRASKA.—No pamphlets issued.

NEVADA.—No state board of health.

NEW HAMPSHIRE.—Tuberculosis, diphtheria, flies, scarlet fever.

NEW JERSEY.—Tuberculosis, small-pox, vaccination, malaria, diphtheria, pure food, flies, measles, ophthalmia neonatorum, contagious diseases of animals, transporation of the dead, anthrax.

NEW MEXICO.—No pamphlets issued.

NEW YORK.—Tuberculosis, meningitis, small-pox, vaccination, diphtheria, flies, scarlet fever, measles, poliomyelitis, common drinking cup, school hygiene, whooping-cough, cancer, typhoid.

NORTH CAROLINA.—Tuberculosis, malaria, flies, hookworm, typhoid, sanitary privies, septic tanks, sanitary care of water-sheds.

NORTH DAKOTA.—Tuberculosis, care of infants, flies, poliomyelitis, typhoid, slaughter-houses, ventilation, hygiene of the eye and ear, spitting, pure ice.

OHIO.—Tuberculosis, care of infants, small-pox, vaccination, diphtheria, scarlet fever, ophthalmia neonatorum.

OKLAHOMA.—Tuberculosis, care of infants, small-pox, vaccination, pure food, flies, measles, poliomyelitis, ophthalmia neonatorum, common drinking cup, whooping-cough, pneumonia, typhoid.

OREGON.—Tuberculosis, small-pox, vaccination, pure milk, rabies, slaughter-houses, meat inspection.

PENNSYLVANIA.—Tuberculosis, care of infants, small-pox, vaccination, flies, poliomyelitis, school hygiene, bubonic plague, rabies, cancer, board of health work, water-supply, general health pamphlets.

RHODE ISLAND.—Subjects of pamphlets not specified.

SOUTH CAROLINA.—Tuberculosis, vaccination, measles, diphtheria, flies, hookworm, scarlet fever, measles, poliomyelitis, common drinking cup, whooping-cough, typhoid, school inspection, pellagra, clean-up day.

SOUTH DAKOTA.—No pamphlets issued.

TENNESSEE.—Tuberculosis, small-pox, vaccination, malaria, pure food, flies, hookworm, scarlet fever, measles, poliomyelitis, ophthalmia neonatorum, common drinking cup, adenoids, school hygiene.

TEXAS.—Small-pox, diphtheria, scarlet fever.

UTAH.—Tuberculosis, meningitis, care of infants, vaccination, diphtheria, pure food, scarlet fever, poliomyelitis, common drinking cup, school hygiene, whooping-cough, pneumonia, typhoid.

VERMONT.—Tuberculosis, diphtheria, pure food, scarlet fever, measles, ophthalmia neonatorum, common drinking cup, whooping-cough.

VIRGINIA.—Tuberculosis, care of infants, vaccination, diphtheria, flies, hookworm, scarlet fever, measles, school hygiene, whooping-cough, cancer, typhoid, pure water, sanitary privies, summer troubles.

WASHINGTON.—Tuberculosis, small-pox, flies, poliomyelitis, typhoid.

WEST VIRGINIA.—Tuberculosis, small-pox, diphtheria, pure food, scarlet fever, measles.

WISCONSIN.—Tuberculosis, care of infants, small-pox, diphtheria, flies, scarlet fever, poliomyelitis, ophthalmia neonatorum, common drinking cup.

WYOMING.—Tuberculosis, meningitis, small-pox, diphtheria, pure food, scarlet fever, measles, typhoid.

PUBLIC HEALTH PAMPHLETS ISSUED BY STATE BOARDS, ARRANGED BY SUBJECT

TUBERCULOSIS.—California, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming.
Total number of states, 33.
Estimated number of pamphlets issued in 1910, 600,000.

MENINGITIS.—California, Michigan, New York, Utah, Wyoming.
Total number of states, 5.
Estimated number of pamphlets issued in 1910, 5,000.

CARE OF INFANTS.—California, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, North Dakota, Ohio, Oklahoma, Pennsylvania, Utah, Virginia, Wisconsin.
Total number of states, 16.
Estimated number of pamphlets issued in 1910, 100,000.

SMALL-POX.—California, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Montana, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Washington, West Virginia, Wisconsin, Wyoming.
Total number of states, 19.
Estimated number of pamphlets issued in 1910, 70,000.

VACCINATION.—California, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Montana, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont.
Total number of states, 21.
Estimated number of pamphlets issued in 1910, 110,000.

MALARIA.—California, Maryland, Mississippi, New Jersey, North Carolina, South Carolina.
Total number of states, 6.
Estimated number of pamphlets issued in 1910, 39,000.

DIPHTHERIA.—California, Illinois, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, New York, Ohio, South Carolina, Tennessee, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.
Total number of states, 23.
Estimated number of pamphlets issued in 1910, 190,000.

PURE FOOD.—California, Indiana, Iowa, Kansas, Louisiana, Maryland, New Hampshire, New Jersey, Oklahoma, Tennessee, Vermont, West Virginia, Wyoming.
Total number of states, 13.
Estimated number of pamphlets issued in 1910, 135,000.

FLIES.—California, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Mississippi, Montana, New York, North Carolina, North Dakota, Oregon, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, Wisconsin.
Total number of states, 24.
Estimated number of pamphlets issued in 1910, 260,000.

HOOKWORM.—California, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia.
Total number of states, 7.
Estimated number of pamphlets issued in 1910, 160,000.

SCARLET FEVER.—California, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, New York, Ohio, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.
Total number of states, 23.
Estimated number of pamphlets issued in 1910, 180,000.

MEASLES.—California, Idaho, Illinois, Indiana, Kansas, Maryland, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming.
Total number of states, 19.
Estimated number of pamphlets issued in 1910, 120,000.

SEX HYGIENE.—California, Indiana, Maryland.
Total number of states, 3.
Estimated number of pamphlets issued in 1910, 9,000.

POLIOMYELITIS.—California, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, New York, North Dakota, Oregon, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Washington, Wisconsin.
Total number of states, 19.
Estimated number of pamphlets issued in 1910, 100,000.

OPHTHALMIA NEONATORUM.—California, Indiana, Kansas, Kentucky, Maryland, Massachusetts, New Jersey, New York, Ohio, Oklahoma, Oregon, Tennessee, Vermont, Wisconsin.
Total number of states, 14.
Estimated number of pamphlets issued in 1910, 45,000.

COMMON DRINKING CUP.—California, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Vermont, Wisconsin.
Total number of states, 15.
Estimated number of pamphlets issued in 1910, 160,000.

ADENOIDS.—California, Indiana, Louisiana, Michigan, Tennessee.
Total number of states, 5.
Estimated number of pamphlets issued in 1910, 15,000.

SCHOOL HYGIENE.—California, Indiana, Louisiana, Michigan, Minnesota, New York, Oregon, Pennsylvania, Tennessee, Utah, Virginia.
Total number of states, 11.
Estimated number of pamphlets issued in 1910, 150,000.

WHOOPING-COUGH.—California, Idaho, Indiana, Kansas, Maryland, Michigan, New York, Oklahoma, South Carolina, Utah, Vermont, Virginia.
Total number of states, 12.
Estimated number of pamphlets issued in 1910, 100,000.

PNEUMONIA.—California, Indiana, Iowa, Maryland, Michigan, Oklahoma, Utah.
Total number of states, 7.
Estimated number of pamphlets issued in 1910, 30,000.

CANCER.—California, Michigan, New York, Pennsylvania, Virginia.
Total number of states, 5.
Estimated number of pamphlets issued in 1910, 18,000.

TYPHOID.—Idaho, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, New York, North Carolina, North Dakota, Oregon, Oklahoma, Pennsylvania, South Carolina, Utah, Virginia, West Virginia, Wyoming.
Total number of states, 18.
Estimated number of pamphlets issued in 1910, 220,000.

BUBONIC PLAGUE.—California, Pennsylvania.
Total number of states, 2.
Estimated number of pamphlets issued in 1910, not known.

In addition to the list of subjects submitted, the following pamphlets are also issued by one or more boards:

Municipal Problems, Sewage Disposal, Tropical Diseases, Sanitary Privies, Pollution of Streams, Pure Milk and Dairies, Tuberculosis Among Dairy Herds, Sanitary Bakeries, Cats as Carriers of Disease, Two-Wheeled Push-Carts, Pure Drugs, Care of the Teeth, Sanitation of Buildings, Disinfectants, Habit-Forming Drugs, Condensed Milk, Resort Sanitation, Rabies, Spitting, Tetanus, Treatment of the Drowned, Lodging-Houses, Contagious Diseases, Diseases of Animals, Transportation of the Dead, Anthrax, Septic Tanks, Sanitary Care of Water-Sheds, Slaughter-Houses, Ventilation, Hygiene of the Eye and Ear, Pure Ice, School Inspection, Pellagra, Summer Troubles.

SUMMARY

Total number of states issuing pamphlets for public...	36
Total number of subjects.....	38
Total number of pamphlets distributed in 1910 (estimated)	2,800,000

As a means of cooperating with the existing state and municipal health organizations, the Council has under consideration the preparation of a standard series of public health pamphlets by recognized authorities, such pamphlets to be printed in the Association office and supplied to state and municipal boards of health, philanthropic organizations and others at cost. The preparation and standardization of these pamphlets by the Association, and their publication in large quantities, will enable us to furnish them at a lower figure than they could possibly be obtained from any other source, thus enabling health officers and boards to secure a larger amount of material for the same amount of money than could otherwise be obtained. The Council plans to have prepared during the coming year a series of at least twenty pamphlets on public health similar to the excellent series prepared and issued by the Bureau on Protection of Medical Research.

LEGISLATION REGARDING CORONERS

At the St. Louis session a resolution regarding the office and duties of coroners was referred by the House of Delegates to the Council, with instructions to inquire into the medical and legal aspects of the question and as to the advisability of legislation separating the medical from the judicial functions of the coroner's office. The secretary has communicated with the secretaries of the various state boards of health and has secured a considerable amount of data on this question but the Council is not yet prepared to submit a report and requests further time for consideration.

B. REPORTS OF SUBORDINATE COMMITTEES

In addition to the work enumerated above, the Council presents herewith the reports of the chairmen of the committees which by act of the House of Delegates or by order of the Board of Trustees have been placed under the Council. On account of their importance these reports are submitted verbatim and the Council bespeaks for them the careful consideration of the House of Delegates. The report of the Committee on Uniform Regulation of Membership is of special importance at this time. The report of the Woman's Public Health Education Committee shows the work done through this valuable agency for public education. The report of the Committee on Visual Standards of Pilots is one of progress. The reports of the Committee on Prevention of Blindness and of its subcommittees show the enormous development of this work in the past four years under the able leadership of Dr. Lewis. The Council asks that these various reports be referred to the appropriate reference committees and that such criticisms and suggestions be made as will enable the work in all of its departments to be greatly advanced during the coming year.

In concluding this report of its organization and of its first year's work, the Council desires to put on record an avowal of its clear realization of the importance, both to the profession and to the people, of the work assigned to it and to the possibilities of such work for good. And realizing the enormous opportunities for service that the Association has placed within its grasp, the Council necessarily realizes fully its responsibility to the Association for the proper discharge of the trust that the Association has placed on it. By carefully planned and continuous effort, the Council hopes to direct and educate public opinion in favor of such wise, fair and effective measures as may be needed to improve the physical welfare of the people and to improve the status of the medical profession.

Respectfully submitted,

HENRY B. FAVILL, Chairman.
JOSEPH N. MCCORMACK.
HENRY M. BRACKEN.
WILLIAM C. WOODWARD.
WALTER B. CANNON.
FREDERICK R. GREEN, Secretary.

REPORTS OF SUBCOMMITTEES COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

REPORT OF THE PUBLIC HEALTH EDUCATION COMMITTEE

To the Council on Health and Public Instruction:

The report of this, our second year of committee work, should be read as a continuation of last year's report, for what has been done this year is an outgrowth and natural sequence of that previously accomplished.

The various county medical societies, which last year appointed committees to work with the local divisions of the Public Health Education Committee, have continued and enlarged their work this year, and the number of county medical societies to form such committees has greatly increased.

Public health education, as represented by the state divisions of our committee, has also been made part of the regular work of Pennsylvania, and a number of other state societies.

This step is of great importance to the American Medical Association, because the continuation of the work is thereby assured, and as it grows in every community it will be recognized as a national medical philanthropy, and will put the American Medical Association in the position of making its organization of the greatest service to humanity, by putting before the people gratuitously the knowledge which insures health, and thereby increases not only their personal happiness, but raises the standard of their efficiency in the community.

The criticism is constantly made, not only by the laity, but even by members of our profession, that physicians do less than any other class of people in the present world-wide social evolution for higher standards of living.

Colleges, churches, settlements, prison reform associations, the Consumers' League, the Young Men's and the Young Women's Christian Associations, the antituberculosis societies, the Child Hygiene organization and all the other movements of the last thirty years are credited to public-spirited members of the laity, whereas as a matter of fact physicians are among the most active and effective workers in all these and many other constructive lines of activity. Among the public-spirited professors, who is more active than Dr. Richard Cabot of Boston and Dr. Elizabeth B. Thelberg of Vassar? No one contributes more generously to settlement work than Dr. Ira Wile and Dr. Antonio Stella of New York City and Dr. Amelia Dranga of Pittsburg. No one was more active in restoring San Francisco to a healthy condition after the earthquake and plague than Dr. Adelaide E. Brown.

In prison reform no one works with broader vision nor greater earnestness than Dr. Annie S. Daniel and Dr. Jane E. Berry of New York City. Back of all the health work of the Consumers' League stands Dr. Mary Bissell; and the directing mind of all the health protection that benefits young girls through the Young Women's Christian Association, is that of Dr. Anna L. Brown.

In school hygiene no one has done more than Dr. Luther Gulick of New York City, and no one has worked more effectively for child hygiene than Dr. Caroline Hedger of Chicago and Dr. Sarah T. Mayo of New Orleans. The most difficult and far-reaching sociologic movement for health that has ever been put forward has had for its leader Dr. Prince A. Morrow. No one has done so much for the prevention of blindness as Dr. F. Park Lewis.

The antituberculosis work is led by Dr. Farrand and the money for the first county hospital for tuberculosis in New York State was raised by Dr. Mary Gage-Day. For every physician we have mentioned we could name hundreds who are doing equally good work in practically every state. The able health work done through federated clubs is planned and directed by women physicians, as Dr. Elizabeth Kane in Tennessee, Dr. Ellen L. Stevens in Florida, Dr. Jennie McGowan in Iowa, Dr. Viola Coe in Oregon and Dr. Frederika Phillips in Seattle, Washington; but all of these are regarded by the public as individual and more or less isolated instances. Therefore, it seems to us of the utmost importance, from a national standpoint, to have a committee which registers the work done gratuitously for social and physical health in the United States by physicians.

The report of our committee shows only a small part of the educational work done by men and women physicians throughout the country; for a great many public-spirited members of our profession had been carrying on such work for years before our committee began its organized activity, and a great deal is now being done independent of our committee, but the report shows physicians bringing together the fruits of their experience and putting it into systematic form, extending and developing the work through comradeship of effort, and placing on record in concise form the experience and needs of one community which may contain helpful suggestions for the work in another community.

Last year our committee reported 2,250 lectures given to 102,575 people, this year over 2,800 lectures have been given to more than 230,623 people, and beside the educational work in lectures valuable work has been done along other lines for the prevention of disease, as you will find by reference to the individual reports, submitted herewith. For instance Dr. Frances Bradley, state secretary for Georgia, reports:

We have secured from Governor Brown the appointment of an Annual Health Day, the fourth Friday in March, to be observed throughout the state by all schools, women's organizations and other orders, by means of lectures, stereopticon slides, charts, etc., in some cases by exhibits on hookworm, tuberculosis, value and care of milk and kindred subjects.

Through the state federation we have secured the appointment of two "cleaning-up days," one each in April and October.

We have secured from various railroads the promise to install sanitary drinking cups in every train running through Georgia.

We have secured equipment for two open-air schools, to begin in September.

We have added materially to the number and efficiency of our play-grounds.

We have at last broken into our sacred public-school system with popular lectures by physicians of the state on matters of hygiene and sanitation.

We have been instrumental in securing medical inspection of schools, in one or two places, by cooperating with the Rockefeller Commission for Hookworm Investigation in this state.

Through the cooperation of the Fulton County Medical Society we have had a course of open meetings, four in number, under the auspices of that body and the State Federation of Women's Clubs, in which the general public participated.

For the coming year we propose to increase the present work and, in addition, to establish for rural districts traveling libraries on hygiene and sanitation.

We plan to secure an appropriation from the legislature for the extension of education for farmers' wives, especially along the lines of hygiene and sanitation.

We shall have attractive rest rooms and sanitary wagon yards in every town in the state for farmers and their families.

Extension of civic work and public health education among the colored race will also receive careful attention another year.

The following extracts from letters received during the year from Dr. Bradley are typical of those from other state secretaries:

December 5: We had our first meeting Saturday evening between the Fulton County Medical Society and the State Federation of Women's Clubs. It was the success of the season. The assembly room of the Carnegie Library, where our county medical society meetings are held, could not hold the crowd, so we will have to have a larger place for the next lecture, which will take place early in January. This week a lecture with lantern-slides of local conditions will be given in Whittier Mills, where they have 1,200 operatives, as we wish to carry the work to those who need it most.

A series of open meetings is being given under the auspices of the Fulton County Medical Society and the Georgia Federation of Women's Clubs.

January 25: The little towns of Georgia are clamoring for help! The work in Atlanta is doing famously! There is a tremendous opportunity for raising the health standard. We are doing extensive work in the cotton factories, where the work is greatly needed.

February 4: Our second meeting totally eclipsed the first. There was not even standing room! Must rent bigger quarters! I am going to half a dozen adjacent towns this month, to schools, clubs, etc.

A letter from Dr. Hainer of Sioux Falls, S. D., reported that in Sioux Falls the medical society was very willing to cooperate with our committee, and that Dr. H. M. Freiburg of Watertown and Dr. J. G. Parsons of Sioux Falls were very actively interested in helping with the work.

In North Carolina, in order to get a valuable series of articles on the prevention of disease, prizes were given for the best essays written on public health subjects.

In Kalamazoo in the summer months the work of the Public Health Education Committee was kept before the minds of the people by brief articles in the daily press on health topics, appropriate to the season.

In Iowa last year Dr. Kinner, our county chairman for Dubuque, started, as a piece of committee work, the playground movement which has resulted in one of the finest and most perfect playground systems in America.

In Hawaii a "Conservation Day" has been arranged for, a certain day being set aside in various colleges, schools, settlements and church societies for the consideration of the conservation of health.

In Ohio the moving picture show is being advocated as a means of teaching the people in regard to "Insects and Disease," "Tuberculosis," etc.

The Ohio division of our Medical Literature Subcommittee is carefully selecting a few books to recommend, to form what they term a citizens' shelf.

In New York leaflets in Polish, Italian, Yiddish and German, on "Prevention of Tuberculosis," have been distributed, by our county chairman, to the residents of the city speaking these languages, and we have been active in promoting the use of bubble fountains and of individual drinking cups and individual paper towels in schools, also in promoting a more hygienic condition of public conveyances—having secured in New York City a more adequate ventilation of the crosstown street car lines, and made education so popular, that one woman asked for a book on tuberculosis to take home to read to her husband in the evenings.

In Washington State, as the result of a talk given by our state secretary—telling the plans and scope of our work—the Century Club set apart a day—called "Doctor's Day" and invited other clubs and the public to a most successful meeting.

They have determined to make this "Doctor's Day" an annual event.

The committee work is conducted by the members of the Central American Medical Association Committee who appoint state secretaries; these further subdivide the work by appointing county chairmen. In five large cities we have especial city secretaries.

There are at present 9 members of the central committee, 45 state secretaries and 238 county chairmen, besides assistant secretaries, and members of subcommittees. All are members of the American Medical Association and serve entirely gratuitously; there are over 300 officers in our committee, and with each of these, at a conservative estimate, six other physicians are associated, making in all a total of no less than 1,800 members of the American Medical Association who during the last two years have, as a definite and organized piece of work, carried forward this American Medical Association campaign of health education. It is following this year the same lines as last in Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin and Wyoming; also in Alaska, District of Columbia, Hawaii and Panama. Work was begun under the committee this year in Alabama, Nevada, North Carolina, Vermont, and West Virginia.

The plan of work used in all states includes the use of a leaflet, the name of the committee officer distributing it being written in the blank space.

The gratifying development of our committee work is in large part due to the progressive and at the same time conservative manner in which it has been carried forward. In Panama, for instance, at the beginning of the work last year Dr. William C. Gorgas, who was then President of the American Medical Association, presided at the first meeting, held under the auspices of our committee, and expressed his entire approval and hearty endorsement of the campaign to be conducted by members of the American Medical Association for the lessening of disease through education.

The physicians who have been asked to represent the committee in each locality have been selected on recommendation of their county medical societies or state health officers.

The general recognition, on the part of the public, of the importance of systematic teaching on the prevention of disease is shown by the impetus our committee has definitely given to health education; for instance, in Ohio and many other states. Last year in New York City, ours was the only course of lectures; this winter there have been six courses, arranged by scientific and social groups, many of the topics and speakers being the same as in our course last winter, as you will see by reading the separate report for the County of New York, herewith submitted.

Mrs. M. W. Barry of North Texas College and secretary of the Education Department of the National Federation of Women's Clubs, wrote asking our cooperation regarding educational work in the federation, also requesting a bibliography on sex hygiene suitable to be placed in the hands of mothers and teachers, and a list of our committee officers. Later she wrote that she had sent to each chairman on the Federation Education Committee the names and addresses of the state secretaries of the American Medical Association Public Health Education Committee.

The helpful results of our two years of committee work have been widely distributed, as the following examples will show:

Dr. F. Park Lewis, chairman of the American Medical Association committee on Prevention of Blindness, Miss Louisa Lee Schuyler and Miss Caroline C. Van Blarcom, the executive secretary of the National Committee for the Prevention of Blindness under the Russell Sage Foundation, conferred with the chairman of the American Medical Association Public Health Education Committee regarding an extension of their work, and were advised to provide many duplicates of the one set of lantern slides they then had for illustrations, and also to have a leaflet made to accompany these, giving the most important statistics and data bearing on their work. An official circular letter was written putting them in touch with the state secretary and county chairmen of our committee in all states and the officers of our committee were urged to lay stress on this subject in the educational campaign they were conducting. This was done in the most cordial spirit, and individual instances will be found in the reports of our New York and Tennessee state secretaries.

The secretary of the Health Department of the National Y. W. C. A. writes that the interest of their members in health education is rapidly increasing through our active cooperation. We also put her in touch with all our state secretaries and county chairmen, for we are very glad to help her arouse in the 193,000 women in their national Y. W. C. A. a conscience regarding the duty of being well.

A glance through the detailed reports submitted herewith will show the service we have rendered to the cause of social hygiene and the activity of our committee on general health education in mothers' clubs and federated women's clubs throughout the country. In New York the president of the New York City Mothers' Club said that the only reason they had no individual lectures on health was that the lectures under our committee at the New York Academy of Medicine were so practical that they all went there to hear them each week.

One of the best pieces of work begun by our committee last year under Dr. S. Josephine Baker and continued this year by Dr. Belle J. McDonald, the New York Secretary of our Subcommittee on Affiliated Public Health Work, was a number of letters written to the boards of health in each state and the tabulation of their answers submitted as the report of that subcommittee. This is of especial value as we wish to have our committee members in each state work in close touch with the boards of health, avoiding duplication of effort, and educating the public to the importance of cooperation in health matters.

Our Subcommittee on Medical Literature has compiled a bibliography, herewith submitted, of books and papers which will be found useful as a reference list by those who wish information on the prevention of diseases; the list is a compilation of data sent from forty states by members of this subcommittee. It is of course not an exhaustive list, but its usefulness is increased by being concise.

There is so much demand for a list of reliable sources of information that the hygiene committee of the New York City Federation of Women's Clubs asked permission to reprint, for local distribution, the one compiled by our committee, and have done so at their own expense.

A number of libraries, among them the Library of Pratt Institute, Brooklyn, has offered to make a special point of having for circulation the books recommended by our committee.

We have received very great assistance from many libraries in the free use of their halls for lectures, and the Library Committee of the New York Academy of Medicine took the trouble to put on a table in the room adjoining the lecture hall, all the standard books bearing on the topic of the day, so that teachers and others who were present could see the type of books and make a list of such as they wished later to come to the library and read.

We do not have any literature for distribution because such organizations as the Tuberculosis League, the Pure Food Committee of the Consumers' League, the Special Committee for the Prevention of Blindness, etc., have very practical leaflets for which they are anxious to increase their avenues of distribution; we have therefore thought it best to recommend to each of our county chairmen that she cooperate with those working for the betterment of health locally, by carefully selecting such leaflets as are of educational value and free from all advertisement, allowing these to be used in connection with our committee work, whenever the organizations printing the same wished this done.

We are gradually collecting a set of reprints of separate lectures given in the various series in each state, with a view to eventually selecting from these a number which will be valuable to have reprinted in large numbers for general distribution, without giving the names of the authors.

The subcommittee on cooperation, of which Dr. Phoebe M. Van Voast is New York City Secretary, has rendered valuable service in writing to the secretaries of all associations and organizations doing work along lines similar to ours and keeping in touch not only with their routine methods, but answering requests to have our committee officially represented at their congresses and conventions, this being done at state meetings of the boards of health, at conferences of charities and corrections, at the meeting of the American School Hygiene Association and the meeting of the National Education Association, etc., a member of the committee living in the state where the conference is held acting as delegate.

The National Education Association which meets in San Francisco in July, 1911, has asked to have printed for distribution to their members at that time, a list of our committee officers and the topics recommended in our plan of work leaflets, in order that their association and ours may act together throughout the country.

The Committee on Cooperation has answered the many requests which have come to us for copies of our annual report and requests for information regarding opportunities for local and national cooperation, as for instance a recent letter from the Canadian Household Economic Association of Toronto, which is working with the Conservation Commission of Canada and the National Council of Women; also a request for data from Appleton & Co., the editors of the American Year-Book, and others who compile compendiums of what is being done throughout the United States along various constructive lines.

In submitting this report we regret that we cannot give a full statement of all the work which has been done by those who have so generously given of their time and knowledge, for it has meant a great deal of public spirit on the part of physicians whose lives are filled with the exacting demands of laboratories, and private and hospital practice.

Respectfully submitted,

ROSALIE SLAUGHTER MORTON, Chairman.
M. ALICE ASSERSON, Secretary.

REPORT OF THE COMMITTEE ON UNIFORM REGULATION OF MEMBERSHIP

To the Council on Health and Public Instruction:

This committee was appointed in accordance with the recommendation of the Secretary made in his report for 1908 at the Chicago session. In this report, the secretary emphasized the difficulty in enforcing the By-Laws of the Association regarding membership, transfers, etc., owing to the conflict existing in the By-Laws of the different state associations. The secretary also emphasized the necessity of uniformity in the essential provisions regarding membership and the great saving in money and time and the increase in administrative efficiency which would follow an adjustment of existing discrepancies. In accordance with the recommendation of the secretary, a committee of three was appointed with instructions to report at the next annual session. At the Atlantic City session in 1909, this committee presented an extended report, tabulating the conditions which exist in the various state associations and showing the importance of systematizing our present haphazard and confused methods of regulating membership. The committee recommended that it be continued for another year. On the day following the presentation of this report, the House of Delegates referred to this committee a resolution presented at the Chicago session by Dr. W. H. Sanders and referred to the Committee on Organization. This resolution referred to the revision of the Constitution and By-Laws of the American Medical Association. As the Committee on Organization had not done any work on this subject during the year it recommended that the resolution be referred to the Committee on Uniform Regulation of Membership, which recommendation was concurred in by the House.

At the St. Louis session in 1910, this committee presented a report consisting of three parts. The first consisted of recommendations for changes in the Constitution and By-Laws of the American Medical Association; the second consisted of recommendations regarding amendments to the Constitution and By-Laws of county and state societies governing disciplining of members; the third contained the recommendations regarding the uniform regulation of membership, the original purpose for which the committee was constituted. In this report, the committee renewed its recommendation of the previous year (1) that all state associations be requested to make their fiscal year conform to the calendar year and that component county societies be requested to adopt the same rule; (2) that all county and state societies be requested to adopt by-laws providing that membership shall continue only for the year for which dues are paid; (3) that the roll for each county and state society be made up each year to include as members in good standing only those who have paid their dues for the current year on or before a certain date; (4) that dues be pro-rated for fractions of a year and (5) that the committee be continued and instructed to prepare a complete system of books, blanks and regulations for the use of county and state societies and the American Medical Association for submission to the House of Delegates. This report was referred to the Reference Committee on Amendments to the Constitution and By-Laws. This committee, on the second day, submitted a report embodying modified amendments to the Constitution and By-Laws and making certain recommendations regarding the remainder of the report on Uniform Regulation of Membership. The House postponed consideration of the amendments to the By-Laws until the next day, at which time they were discussed, modified and adopted, but the remainder of the report, including the recommendations referred to the committee was not acted on; instead a supplementary report of the reference committee was adopted simply recommending that the committee be continued.

The committee begs again to call the attention of the House of Delegates to the vital and urgent importance of the adoption of a systematic plan for the regulation of membership. In the report of the Committee on Organization, made at the St. Paul session in 1901, the advantages of uniform membership provisions and for a plan by which members moving from one state to another could transfer their membership from one society to another without a break in membership, was emphasized, in fact this is one of the most important subjects discussed by the committee. Furthermore, in the uniform card system made up by the Committee on Organization in 1902, a recommendation for adoption of permanent record cards and transfer cards was provided. It is perfectly obvious that no adequate system of membership can possibly be devised unless county and state societies observe uniformity regarding the general principles of membership regulation. If each society follows its own fancies regarding the beginning and termination of the fiscal year, the length of residence necessary for eligibility, etc., no transfer system is possible. Furthermore, if a county society has the right to disregard a transfer card issued by another county society to a member in good standing and to refuse a member bearing such a transfer card membership in the society of the county to which he goes, then it is equally clear that any system of uniform regulation is impossible. It is becoming more and more evident, as your committee has repeatedly urged, that this is one of the most important questions which the organization has to consider. It is to-day causing much unnecessary expense to county, state and national organizations; what is far more important, it has resulted in dissatisfaction and alienation on the part of individual members on account of fancied injustices which are unavoidable under existing conditions and which the executive officers of the different parts of the organization cannot avoid. For instance, if a physician in good standing in one county society removes into the jurisdiction of another county society taking with him a transfer card properly made out, and if the county society into whose jurisdiction he moves, for any reason, denies him membership, he has at present no recourse, while the secretary of the American Medical Association is placed in a position where he must either drop the member's name from the list of members of the American Medical Association, which may work an injustice to the member, or continue to carry him as a non-resident member of the county from which he moved, regardless of the action of the county society in whose jurisdiction he resides. This is an injustice to the county society and is a palpable infringement on the right of the county society to regulate its own membership matters. Yet it is impossible under present conditions to avoid the perpetration of an injury of the rights of someone concerned.

The relative jurisdiction of county, state and national bodies, as well as a clear-cut and definite method of regulating membership, including the transfer of membership from one component part of the organization to another, should be carefully worked out and then put in force in all parts of the organization.

The experience of the committee in the past three years leads us to believe that this work cannot properly be done through correspondence or by attempts to modify the By-Laws or frame recommendations during the rush and excitement of the annual sessions. It is a matter which should be taken up deliberately and given careful consideration. Prominent and representative executive officers in various county societies, as well as of state societies, should be called into consultation and asked to aid by criticisms and suggestions. The report of the committee should be carefully drafted long enough in advance of the annual session to admit of its being sent to a large number of members and officers for criticisms, and when presented to the House of Delegates as the finished product, the results of the deliberations of the committee should not be nullified without the strongest reasons for such action.

In view of the experience of the last three years, your committee has refrained from any further practical recommendations, believing that in spite of the best of intentions, it has not pursued the wisest method in attempting to investigate this question. With a view to getting on the right track, the committee makes the following recommendations:

We recommend that the present committee be continued, or if the House of Delegates sees fit, that a new committee of seven state secretaries be constituted;

That the trustees be requested to appropriate a sufficient amount to enable this committee to hold at least two meetings at the headquarters of the Association in Chicago;

That to this committee be referred the two previous reports of our committee together with their recommendations and that the committee be instructed to take up the entire question of membership in county, state and national organizations with their relationship to each other, including qualifications for admission to membership, fiscal year, membership transfers, method of reporting and recording membership by secretaries of county, state and national bodies, together with the formulation of a complete system of cards, blanks, reports and forms, with a view to unifying the membership of the entire organization on a fair, equitable and systematic basis.

We recommend that this committee be instructed to hold at least two meetings to secure criticisms and opinions from any members or officers of the organization, that may be needed, and, if possible, to present to the House of Delegates at the next annual session a complete plan regarding the regulation of membership throughout the entire organization.

Respectfully submitted.

THOMAS MCDAVITT, Chairman.
W. A. STEINER.
J. H. J. UPHAM.
FREDERICK R. GREEN.

REPORT OF THE DIRECTOR OF POSTGRADUATE STUDY

To the Council on Health and Public Instruction:

I submit herewith a report of the work of the course of postgraduate study for the fourth year. The course as originally planned consisted of a cycle of four years, hence this is the last year of the first cycle. It is expected that the course for the next cycle will follow in a general way that of the first, but as we profit by the experience of this cycle the subject matter for the next four years will require modification and certain changes, if the interest of the societies is to be maintained.

The outlines for this year were printed and ready for distribution by August 1, 1910, and a large number of the societies which had been following the course before were ready for the work by September 1. The outlines distributed for the year were in the form of the Warren County (Ky.) Medical Society programs, most of the societies using them by filling in the names of the teachers for the different topics.

The increase in number of societies and in interest in the work was rather marked for the first three years. During the fourth year the course has not been lacking in interest, for many of the societies familiar with the work have continued it in a systematic way during this year, but the number of new societies has not been so great as heretofore. In our opinion the cause for this failure to get the usual number of new societies to take up the course is that Dr. McCormack has not been able in his work to visit as many societies as has been his custom. We note further that most of the new societies taking up the work during this year have been those visited by Dr. McCormack, showing, as we have suggested heretofore, that one familiar with the plans and details of the course can much more easily and readily arouse an interest and enthusiasm in the local societies.

A number of secretaries have written already to know what is to be done with the work for next year, as they are anxious to continue some systematic course of study, recognizing in this plan one of the best means of maintaining interest in the local county society, the unit in our organization.

Very respectfully,

JOHN H. BLACKBURN, Director.

REPORT OF THE COMMITTEE ON VISUAL STANDARDS FOR PILOTS.

To the Council on Health and Public Instruction:

The committee to confer with the Department of Commerce and Labor with a view to obtaining the adoption of suitable standards for the examination of the eyes of navigators operating under federal law begs leave to report that, after a conference with the secretary of the department, at which the Board of Supervising Inspectors of the Steamboat Inspection Service was present, the Department of Commerce and Labor has adopted the recommendations of your committee with one slight modification, and after July 1 of this year all navigators under the control of that department will be examined by the standards which your committee submitted to them. The text of the resolution adopted by the Board of Supervising Inspectors of the Steamboat Inspection Service at the meeting of January, 1911, is as follows:

Resolved, That it is the sense of the Board of Supervising Inspectors of Steamboats, after a careful consideration of the recommendation of William Campbell Posey, M.D., of Philadelphia, Pa., pages 17, 18 and 19, that it be made the basis of an examination required to determine the fitness of any applicant for license as master, mate or pilot, and that the Board of Supervising Inspectors request the U. S. Marine-Hospital Service to make Dr. Posey's recommendations the standard of this examination, with the exception that the examination be required only on the issue or renewal of license, that is to say, every five years.

The committee is highly gratified at the adoption of the standard, for it insures a requisite degree of vision and color-sense in all navigators under the control of the federal government. As was stated in the address of the chairman of the Section on Ophthalmology at the meeting of the Association last year, the more than 4,000 annual examinations of the eyes of masters, mates and pilots in the mercantile marine have hitherto been made in a more or less haphazard manner, the Department of Commerce and Labor having failed to establish any fixed standard of vision, to govern the officers of the Marine-Hospital Service in making the tests.

The standards of visual acuity which were submitted by your committee were determined on after a careful study of foreign standards and after due consideration of the minimum degree of vision a candidate may have and yet be a safe pilot under all conditions of weather. The manner of carrying out each test is fully described in the instructions also submitted with the standards, for the purpose of uniformity and in order that all examining officers may know that they are complying exactly with the orders of the department.

The tests for color are also explained very explicitly and the rules of procedure elaborated so carefully that the examiners need no longer have recourse to a manual on color sense. Under the present laws, candidates for license need pass but the one test, *i. e.*, that on entrance, while under the standards they must submit to reexamination every five years. This enactment will prevent the continuance of navigators in the service whose vision or color-sense may have deteriorated by age or disease.

At the request of the Marine-Hospital Service, a standard of hearing was also submitted by your committee, as no directions for making the test of this special sense had hitherto been specified by the Department of Commerce and Labor.

In requesting the acceptance of its report, the committee would venture to suggest to the House of Delegates that it extend the thanks of the American Medical Association to the present secretary of the Department of Commerce and Labor, the Hon. Charles Nagel, for his interest in the work of the committee and for his aid in securing the adoption of the standards.

Although the adoption of the standards of your committee insures the proper examination of the eyes and hearing of navigators operating under federal law, there will be still a large number of navigators in the United States who will continue to ply their vocation without adequate test of their visual and aural capacity. The committee refers to the large number of branch or state pilots who have charge of the pilotage of all ships in our waters bound to or from foreign ports. By an act of Congress of Aug. 7, 1789, jurisdiction over these pilots was given to the various states, and they are amenable only to state law or municipal regulation and the federal government exercises no control over them.

As was pointed out by the chairman of the Section on Ophthalmology in the address referred to above, investigation revealed that with but few exceptions the commissioners in the various states had failed to enact any definite visual requirements, and that the question of the sight of pilots was left to the pilots themselves; and in no state were visual standards or tests proper or adequate.

It is the desire of your committee, therefore, that it be continued for another year for the purpose of obtaining if possible the enactment of proper federal or state laws to control the examination of this large body of men.

Respectfully submitted,

WILLIAM CAMPBELL POSEY, Chairman.
CHARLES H. WILLIAMS.
WILLIAM H. WILMER.

Philadelphia, May 22, 1911.

REPORT OF THE COMMITTEE ON PREVENTION OF BLINDNESS

To the Council on Health and Public Instruction:

Your Committee on the Prevention of Blindness organized its work by the appointment of a series of subcommittees as follows:

Ophthalmia Neonatorum: F. Park Lewis, Chairman, J. Clifton Edgar, F. F. Wesbrook.

Toxic Amblyopia: George E. de Schweinitz, Chairman, Thomas B. Holloway.

Wood Alcohol Amblyopia: Casey A. Wood, Chairman.
Trachoma: John Green, Jr., Chairman.
Congenital Blindness: Clarence Loeb, Chairman.
Hygiene of the Eyes: William Campbell Posey, Chairman.
Industrial Conditions Affecting the Eyes: Mark D. Stevenson, Chairman.

The reports which they were able to make are merely preliminary, but they indicate how broad and how important this work is.

In the development of this work, an effort was made to correlate the labors of all like organizations in order that the largest results might be obtained with the minimum expenditure of energy. It was realized that the furtherance of any great movement for sight-saving demands the united efforts of educationalists, physicians, health officers, social workers, and indeed of all cases of people interested in the problems of general sanitation. To that end, the subject of the conservation of vision was brought before the teachers of the country at a meeting in Boston last year of the National Educational Association and a committee was appointed. This committee consists of an illuminating engineer, a psychologist, a book-publisher, a school-man and an ophthalmologist. Their first report will be made this year in San Francisco.

Perhaps the most important movement during the past year for the conservation of vision and the prevention of blindness was held under the auspices and through the courtesy of the Russell Sage Foundation, in the rooms of its board of directors in December, 1910. At that time a national association was formed largely designed to supplement the work already being done under the direction of the committee on prevention of blindness of the Russell Sage Foundation. The purpose of this association is:

To collect and standardize existing information on all subjects pertaining to the use and care of the eyes.

To secure the investigation of subjects on which present knowledge is incomplete or contradictory.

To promulgate knowledge relating to the conservation of vision.

For the purpose of carrying out these objects in the most thorough and effective manner the work of the Association has been divided into six different departments, as follows: Department of Diseases and Defects of the Eye, Educational Department, Industrial Department, Department of Statistics and Information, Department of Publicity, and Department of Legislation.

Each department is conducted by a director, with a staff of five or more associates, and such special assistants or committees as may be expedient. All of these departments work under the general direction of the board of managers and the cooperation of the general secretary. All existing associations and committees engaged in similar or collateral lines of work are brought into active participation through representation in the various departments.

Membership in the association is open to everyone interested, either for themselves or for the good of others, in the objects set forth.

The association invites the assistance and cooperation of all who are interested in the various phases of the work of conserving eyesight. In return for such cooperation it offers every assistance in its power, whether for the personal good of the individual member or the work of extending the benefits to others.

The association is neither charitable nor philanthropic in spirit, but strictly humanitarian, believing that a sound mind in a sound body is the birthright of all, and that to insure every individual coming into his natural inheritance is but an act of common justice.

A CONSERVATION OF VISION DAY

In order that the work which is so rapidly progressing under the various state commissions, associations, health boards, medical and educational committees and other bodies may be crystallized in one effective effort, it is proposed that a special day in October, 1913, be chosen as a "Conservation of Vision Day," and that all of these forces combine in emphasizing the practicability and importance of sight-saving.

Such a movement fixing public attention in every city and state on the various phases of unnecessary blindness, with actual demonstrations of the best methods of lighting the home, the school and the work-room, of avoiding accidents, of protecting working men in factories and shops, would do more to develop a popular understanding of the hygiene of the eye and the means to be adopted for its protection than would volumes of scientific treatises.

Your committee recommend that such a day be selected, and that the states and cities be invited to join in the development of such a popular movement. They would recommend that the work as outlined in the valuable reports of the subcommittees be continued; that the American Medical Association Committee on Hygiene and Sanitation approve of a uniform law for the control of ophthalmia neonatorum, and that its enforcement be urged on the health authorities in every state and of every city in the country. In that way, that for which we have been struggling would become an accomplished fact and our country would have the proud satisfaction of being the first to abolish this destructive plague.

Respectfully submitted,

F. PARK LEWIS, Chairman.

REPORT OF THE SUBCOMMITTEE ON OPHTHALMIA NEONATORUM

To the Committee on Prevention of Blindness:

In 1906 it was urged that the blindness resulting from birth infections which contributed one-quarter to the entire population of our schools and asylums for the young blind—which was causing misery beyond estimate and which demanded an annual sacrifice of millions of dollars—was cruel and unnecessary, and that this prodigal waste of human power and human resource must be stopped.

This unending destruction of the eyes of new-born babies which had gone on from time immemorial was and is an anachronism, totally out of harmony with the methods, the aims and the possibilities of modern sanitation. This is a problem so well understood and so simple that it requires for its solution merely that it should be known and that the things necessary to check its ravages once and forever should be done. It seemed, then, that the deplorable losses which we suffer were due to the neglect, to the indifference, or to the carelessness of individuals who omitted the simple well-known precautions required for the prevention of infections, or who failed to appreciate the imperative necessity of immediate and adequate treatment after infections had occurred.

It soon became evident, however, that it was not the simple, ignorant, unclean midwife who ministered to the women of her class, nor was it the poor overworked doctor who was primarily responsible for these deplorable losses, although under the hands of both of these the eyes of the children of the nation were being put out. Primarily and essentially the responsibility rests on society—which in its last analysis means every individual who knows what should be done, and whose influence would aid in the protection of these helpless babies.

Your committee, therefore, undertook to bring the force of society together in order that the augmented power of cooperative endeavor might be obtained. Naturally and properly, the organization necessary for the development of this movement began in our own splendidly organized Association. It was primarily a problem in obstetrics, because the first and most essential treatment devolved on the attendant on the mother; in ophthalmology because it had to do with the care of the eyes; and of public health because it was a communicable disease and because the resultant blindness made its victim in a vast proportion of cases a public charge.

State committees were, therefore, appointed and were charged with the duty of carrying out in the several states a general policy which might be determined by the Association itself. In the furtherance of this plan of coordination, the subject of the control of ophthalmia was then exhaustively taken up with the American Public Health Association, the state and provincial boards of health and the obstetric and gynecologic societies. All of these gave the movement their most hearty and unqualified support.

Then it was that the importance and the practicability of the movement appealed to the directors of the Russell Sage Foundation and the movement became an organized campaign. It was seen at once that the basic necessity in the control of this destructive plague of birth blindness was education—broader, more comprehensive, more popular than had ever been undertaken before. The mothers of the land must be made to realize the peril that menaces their babies, then will there be little doubt that the maternal instinct will secure protection for them. Doctors and midwives must be specifically shown what should be done and the boards of health must see that these instructions are done, if the force of the law needs to be invoked in order that this end may be secured. The importance of right methods of managing the toilet of the new-born child and the necessity of scrupulously exacting care on the part of those who are in attendance on the parturient woman must not only be emphasized, but the detailed methods must be described and repeated so frequently that they become automatically a part of the routine of procedure in every case.

It is not enough that the accredited prophylactic be gratuitously distributed by the health department of the state so that the silver salt need never be lacking, but it should be accompanied by brief but lucid descriptions of ophthalmia neonatorum telling with exact detail to what it is due, how it may be avoided, and of the imperative necessity of right and immediate treatment as soon as infection shall have taken place. A pamphlet on this subject should be regularly issued by every state health board in the United States as a part of its routine work. Then ophthalmia neonatorum should be made everywhere a reportable disease and the best physicians should lend their influence and support in developing a sentiment that will compel the attendant on every case, whether midwife or doctor, to comply with the law in reporting it promptly to the department of public health. Only in this way can eyes be saved that would otherwise be lost.

In Indiana and Dakota, laws have been enacted which make any claims for services on the mother illegal unless the question whether or not a prophylactic has been used, has been answered by the attendant. While the necessity of some vigorous measure is recognized on all sides, it is very doubtful that this is the best way of getting at it and indeed the constitutionality of such a law has been questioned. It deprives the attendant of the right to receive remuneration for what he has done as a penalty for a neglect of another duty which he has omitted. It would seem better if the reporting of births and of existing cases of ophthalmia neonatorum were required by law under penalty and then if the failure to observe the requirements of the law were rigidly and actively prosecuted and the results widely published, it would place the department of health in a position to take the right measures for the protection of babies' eyes at the right time.

This method has been adopted in Cleveland, Ohio, with most gratifying results:

On Jan. 1, 1911, the board of health of the city added ophthalmia neonatorum to the list of infectious diseases to be reported by physicians.

During the months of December, 1910, and January, 1911, the State Board of Registration, through its representative, Dr. A. P. Hammond, arrested twenty-four midwives for unlawful practice. The Society for the Blind caused the arrest of four others for failure to report sore eyes. In a majority of these cases convictions were secured and fines imposed, the fines in some cases being remitted on the condition that the midwife should not practice until such time as she should be able to qualify under the laws of the state.

In December, 1910, the State Board of Health and the State Commission for the Blind jointly began the free distribution to registered midwives and physicians of an outfit containing a prophylactic for ophthalmia and accompanied by a circular giving directions for the care of the eyes.

The object of the committee in its campaign against careless practice of midwives was educational. It has been that and more. It has resulted in the saving of sight to a score of babies. Following the publicity in the newspapers of cases of blindness resulting from neglect of midwives there have been reported to some one of the affiliated organizations represented on the committee thirty-eight cases of ophthalmia in children under 5 years of age. In seven of these the disease had run its course and four were totally blind, while three were partially so. In the remaining thirty-one the disease was still active, and of this number twenty-three have been treated in time and the sight has been saved, six have died from other causes, one is still under treatment and one has lost the sight of one eye.

In Boston the policy of securing the reporting of all cases by prosecuting those failing to do so began in September, 1910. In August, ten cases had been reported; in October after prosecution the number jumped to twenty. The effect of the prosecution had been forgotten in November. Then three other prosecutions were instituted and immediately the reports of cases began to come in to the health board from every side. There were fifteen in December, thirty-four in January, ninety-six in February, while in March the number had reached 118. It becomes perfectly evident, therefore, that ophthalmia neonatorum can be stopped if efforts are made to stop it. Where the power rests in the health board, prosecutions should be instituted and results published broadcast. Where the power does not rest in the board of health, it should be secured.

RECENT PROPORTION OF NEW ADMISSIONS IN SCHOOLS FOR THE BLIND WHO HAVE LOST THEIR SIGHT FROM OPHTHALMIA NEONATORUM—1910

States	New Admissions	O. N.	Per Cent.
Alabama	18	4	22.2
California	..	..	....
Colorado	8	4	50.0
Connecticut	9	1	11.1
Iowa	15	5	33.3
Indiana	..	..	....
Maryland	..	..	....
Massachusetts	42	9	21.4
Minnesota	14	3	21.4
Mississippi	..	..	....
Missouri	26	4	15.4
Montana	9	2	22.2
Nebraska	..	..	....
New Mexico	14	6	42.8
New York	27	6	22.2
North Carolina	59	11	18.6
Ohio	33	8	24.2
Pennsylvania	32	12	37.5
W. Pennsylvania	29	7	24.1
Tennessee	..	..	....
Texas	..	..	....
Wisconsin	16	2	12.5
Nova Scotia	..	..	....
Ontario	..	..	....
Totals	351	84	23.9

In this connection the following recent reports show the comparative value of hospital prophylaxis:

PROPHYLAXIS AS USED IN HOSPITALS

Hospitals	Total births	Cases O. N.	Primary Infections (Not kept separate)	Secondary Infections	Prophylactic
Society Lying-In, New York.	5,683	265			S. N. 1%
Univ. of Pa. Maternity	240	0	0	0	S. N. 1%
Manhattan Maternity	1,314	5	5	..	Ag_2NO_3 1%
Jewish Maternity, New York	1,017	2	2	..	Argyrol 10% or S. N. 1%
Sloane Maternity, New York.	1,810	66	18	48	Argyrol 20%
Boston Lying-In	828	7	7	..	Argyrol 25%
Dr. I. L. Hill's Maternity	999	1	0	1	S. N. 1%
Johns Hopkins	407	0	0	0	S. N. 2%

(Used 1 per cent. silver and argyrol preparations. Best results with silver 1 per cent.)

RESULTS OF PROPHYLACTIC

University of Pennsylvania Maternity: No infections.
Manhattan Maternity: But five cases of O. N. in confinements.
Jewish Maternity, New York: Good; both cases cured.
Sloane Maternity, New York: Good; very little reaction.‡
Boston Lying-In: Seven cases, showing positive smears, and no secondary infections.
Johns Hopkins: Excellent results.

MARCH, 1911.—PROPORTION OF PUPILS BLIND FROM O. N. TRACHOMA, ACCIDENTS AND WOOD ALCOHOL IN SCHOOLS FOR THE BLIND IN THIS COUNTRY

State	Total Pupils in School	Total O. N. No.	%	Total Trachoma No.	%	Total Accidents No.	%	Total Wood Alcohol No.	%
Alabama	89	13	20.2	..	....	5	5.6	.	...
Connecticut	43	10	23.2	..	....	8	18.6	.	...
Iowa	140	50	35.7	8	5.7	15	10.7	3	2.1
Massachusetts	297	90	30.3	..	....	28	9.4	.	...
Mississippi	53	6	11.3	1	1.8	5	9.4	.	...
Missouri	93	20	21.5	7	7.5	14	15.0	.	...
Montana	28	5	17.8	..	....	5	17.8	.	...
Nebraska	61	18	29.5	2	3.2	5	8.2	.	...
New York	152	38	25.0	..	....	14	9.2	1	0.6
North Carolina	313	34	10.3	..	....	25	7.9	.	...
New Mexico	34	18	52.9	10	29.4	3	8.8	.	...
Ohio	250	73	31.2	7	2.8	19	7.6	.	...
Pennsylvania	203	35	41.3	1	0.5	18	3.8	.	...
W. Pennsylvania	130	40	30.8	1	0.8	7	5.3	1	0.8
South Dakota	32	..	....	..	....	5	15.6	.	...
Virginia	11	3	27.2	..	....	3	27.2	.	...
Wisconsin	89	8	8.9	1	1.1	7	7.8	.	...
17 schools	2,018	521	25.3	38	1.8	186	9.2	5	0.2

Respectfully submitted,

F. PARK LEWIS, Chairman.
J. CLIFTON EDGAR.
F. F. WESBROOK.

REPORT OF THE SUBCOMMITTEE ON THE TOXIC AMBLYOPIAS EXCLUSIVE OF METHYL ALCOHOL

To the Committee on Prevention of Blindness:

Your committee includes under the term "toxic amblyopias" all such amblyopias as are caused by the influence of toxic substances introduced from without into the system, and makes no reference to the defects of vision which arise from autointoxication. It is not necessary in presenting this preliminary report to make a distinction between the words amblyopia and amaurosis, inasmuch as they are etymologically synonymous, both signifying dimness of vision, although in literature it is customary to apply the term amblyopia to obscurity of vision and amaurosis to more or less complete loss of vision.

Poisons under the conditions named may directly affect the optic nerve, directly affect the ganglion cells of the retina and produce an ascending degeneration of the optic nerve fibers, directly affect the retinal tissue, produce dulled vision when ordinary examinations do not reveal retinal or optic nerve lesions, influence vision by an action on the iris and the uveal tract generally, and finally, cause various or irregular ocular symptoms, not always associated with marked depreciation of visual acuteness.

The degree of the visual defect may vary from complete blindness, that is to say, the abolition of the perception of light (which is rare), to very slight disturbances of vision, such, for example, as are occasioned by mydriasis or cycloplegia. In this preliminary report, however, and with the time at the committee's disposal, it is not possible to take up a discussion of the relation of the degree of the visual defect to the character of the poisonous agent.

‡ Smears are taken from every discharging eye and examined for gonococcus. In all these sixty-six cases the gonococcus was found but once. The vast majority (forty-eight) were late infections with organisms other than the gonococcus. These do not seem to be prevented by any silver salt, and most of them were slight. All discharging eyes, no matter what the organism, are counted as cases of ophthalmia neonatorum. As stated above, the gonococcus was demonstrated but once in the whole series. No eyes were lost and no opacities or other abnormalities noted on discharge.

1. In order to gain some idea of the frequency of toxic amblyopia, exclusive of methyl-alcohol poisoning, in America, the medical literature pertaining to this subject from January, 1904, to August, 1910, was examined, and 249 references were tabulated. These references may be divided into those which are general; that is to say, references to papers which, in general terms, discussed the toxic action of various poisons on the human system without specific record of ocular complications, and direct references; that is to say, those which discussed the effect of toxic agents on the visual apparatus. Of the 249 papers which appeared during the years named, 211 belong on the general references, as already defined, and thirty-eight to the direct references. In the present communication no discussion of these general papers will be attempted, so that we deal only with thirty-eight communications bearing on this topic. Of these, nineteen describe intoxication amblyopia, and by this term is meant an amblyopia which is caused either by ethyl alcohol or by some substance in which ethyl alcohol is the active agent, or by tobacco, or by the combined effect of these two substances; four, lead amblyopia; five, quinin amblyopia; one, antipyrin amblyopia; two, iodoform amblyopia; one, coffee amblyopia; one, formaldehyd amblyopia; one, salicylate of sodium amblyopia; one, an amblyopia caused by the injection of protargol into the lacrimal sac; one, ptomain-poisoning amblyopia; and two, amblyopia of indefinite etiology.

Naturally, this comparatively small number of cases does not give any adequate idea of the frequency of toxic amblyopia in this country, because, in the first place, many of the papers describe more than one case, and in the second place, only the cases which have found their way into medical literature are here recorded. It does give, however, an idea of the substances which most frequently are the causes of the so-called toxic amblyopia, in so far as our own country is concerned.

2. In order to pursue the question of the frequency of the visual defects from these causes another examination was made, to-wit: The reports of eleven hospitals were examined as to the number of patients applying in the out-patient departments for relief of various ocular defects during various years: One year in one, three years in four, four years in one, five years in four, and six years in one.

The total number of eye patients recorded in these eleven hospitals during these years was 471,975, and among these 523 sought relief from a visual defect depending on the ingestion or action of some toxic substance. It is, however, not possible to tell from these reports what exactly the toxic substance was, as almost without exception the records fail to classify their toxic amblyopias; that is to say, there is no way of telling whether the toxic visual defect was due, for example, to alcohol-tobacco, to quinin, or to any other poisonous agent, although it may be assumed that in the large majority of cases tobacco and alcohol were the offending substances. If we may assume that this is correct, and we think we may, the chief cause of toxic amblyopia in this country furnishes about one patient to every thousand patients who apply for relief in our eye dispensaries. In this respect the statistics of our ophthalmic institutions indicate that tobacco-alcohol amblyopia is much less frequent in this country than, for example, in Great Britain. For instance, during ten years in one hospital in England, among 12,644 out-patients, 153 had tobacco amblyopia, while in an American hospital among almost exactly the same number of patients, not distributed, however, over so many years, that is to say, 12,280 patients, only thirteen cases of amblyopia from tobacco toxemia are recorded.

This again, however, does not give us any true idea of the frequency of this amblyopia in our own country, because it leaves out of consideration the many patients in better walks of life who suffer from this difficulty, and who apply for relief in private offices. In one office in which the records of 1,500 patients were examined, five came on account of tobacco amblyopia, or nearly five times as many as are recorded in the large statistical material which we have quoted from the various hospitals. It is the committee's hope in a future report to ascertain by a more elaborate investigation exactly the relationship of this amblyopia to the frequency of ocular disease as it occurs in so-called private patients, but with the figures thus far recorded we think we have shown that this and other toxic amblyopias, again exclusive of methyl-alcohol poisoning, deserve the investigation which has been entrusted to the committee organized by the American Medical Association. The committee feels that it is necessary to point out the lamentable inaccuracies of many hospital reports in so far as they fail to give a just idea of the relative frequency of the various toxic amblyopias. Not only is there a failure for the most part to distinguish between those which are due, for example, to tobacco and alcohol, and those which are due to other toxic agents, but not infrequently a certain number of cases are accredited simply to amblyopia, and it is impossible to tell whether this amblyopia was a toxic one, or, for example, a congenital amblyopia. More than this, we have omitted from our count all cases accredited to retrobulbar neuritis, because we could not ascertain whether this retrobulbar neuritis was due to some toxic agent, like alcohol or tobacco, or to some infection.

The committee, therefore, in concluding this preliminary and necessarily unsatisfactory report, makes an appeal to those who have charge of hospital statistics that in the future an endeavor shall be made to increase the accuracy of the records.

G. E. DE SCHWEINITZ.
T. B. HOLLOWAY.

REPORT OF THE SUBCOMMITTEE ON BLINDNESS PRODUCED BY THE INGESTION OF METHYL OR WOOD ALCOHOL

To the Committee on Prevention of Blindness:

Since the account published (Poisoning by Wood Alcohol, THE JOURNAL A. M. A., 1904, xliii, 972, 1058, 1117, 1213, 1280) by the late Frank Buller and myself on this form of intoxication, cases of complete or partial blindness from the ingestion of the various forms of "deodorized" or "purified" wood alcohol are of less frequent occurrence. This result is partly due to the widespread discussion of the subject and to the publicity given to the fact that "Columbian spirits" and other forms of "deodorized" methyl alcohol are deadly poisons and not in any sense safe substitutes for ethyl, or grain, alcohol. But far more effective than these influences has been the introduction into this country of a harmless, cheap, tax-free commercial agent known as "denatured" alcohol. In a paper contributed at the end of 1906, to the *British Medical Journal*, I predicted that when the provisions of our "denatured" alcohol bill are carried into effect we shall, as in England, hear no more of wood alcohol poisoning and its annual tale of victims.

This prognostication is, however, only in part justified because we continue to have occasional examples of death, as well as toxic amblyopia and amaurosis either from the drinking of "deodorized" wood alcohol or from its inhalation (mixed with unbreathed air) by varnishers and painters.

In addition to the list of over 300 cases of blindness and death occurring in the United States from the drinking and inhalation of methylated spirits detailed in various journals by myself, a number of toxic cases have been reported by others. For example, Gruening has quite recently (*Archives of Ophthalmology*, July, 1910) given the histories of two more. In the first case blindness was the result of drinking a large quantity of adulterated wine. Both optic discs showed excavations resembling those of glaucoma without tension. In the second case blindness was the result of drinking whiskey, an analysis of which showed from 24 to 43 per cent. of methyl alcohol. In this case there was probably chronic methyl alcohol poisoning with an acute exacerbation. Ophthalmoscopic examination showed the optic nerves to be white, with veiled edges and sheaths of connective tissue surrounding the veins and arteries.

Still more recently two cases of poisoning from the inhalation of varnish fumes have been reported which are so typical —especially from the ocular standpoint—of wood alcohol intoxication that one can be almost certain of the diagnosis from the symptoms alone.

In a correspondence with Dr. Henry R. Hopkins who attended the unfortunates and Dr. Blaauw, the ophthalmologist who examined the survivor, there can be no reasonable doubt but that both victims are examples of this well-known cause of blindness. I submit an extract from a Buffalo newspaper that tells the story:

> Varnishing the inside of a beer vat seems in itself a harmless enough form of employment, but the report of Dr. Henry R. Hopkins, given before the Buffalo Academy of Medicine, would prove conclusively that the reverse is true. This report covers a most interesting case and one which will hardly fail to attract the attention of health authorities throughout the state and bring immediate results in the enactment of remedial legislation.
>
> According to the report as given by Dr. Hopkins, he and Dr. Greene were called on last week to attend the case of two men who had been stricken simultaneously after working as beer vat varnishers in a local brewery. One of these men, Joe Michael, of 422 Madison Street, survived but a short time after finishing his work. His fellow workman, one Lang, residing in Riley Street, has since been stricken totally blind, and with small hope of ever recovering his sight.
>
> In his report Dr. Hopkins said that death in the one instance and total blindness in the other resulted undoubtedly from the breathing of the fumes of wood alcohol, this being one of the predominating ingredients used in the varnish for beer vats. In fact, so strong are the fumes that while these huge vats are being varnished it is necessary to employ a watchman, to keep all lighted cigars and cigarettes without the danger zone—ten feet in most instances.

The case in point is a particularly sad one, as both men have families and were in the prime of young manhood, and the wife of one is about to become a mother.

After the meeting of the society Dr. Hopkins was asked by a *Truth* reporter how he thought the dangers of such employment were to be obviated. This he believed could be effected by the substitution of "denatured" alcohol for wood alcohol, which he believes could be made quite as effective as a varnish ingredient as the other and partaking of none of the danger to human life present in the wood variety. There were on record, he said, seventeen cases of death and total blindness as a result of the breathing of the fumes of wood alcohol, these cases being mostly among varnishers of beer vats.

This is a matter that should immediately enlist the attention of Health Commissioner Froncsak to the end that legislation which will protect this form of labor from the evils above outlined may be enacted. We believe, with the learned doctor, that this can be done by the substitution of denatured for wood alcohol; at any rate, the matter calls for prompt and thorough investigation and effective action.

When we know that England and Germany annually use millions of gallons of a cheap, commercial grain alcohol that has all the advantages of purified wood alcohol, without a single instance of death or blindness among those that work with it, and since our cheap "denatured" alcohol exactly corresponds to the tax-free foreign methylated spirits, there seems to be no valid reason for the employment of this poisonous "deodorized" wood alcohol, which is a continual menace to the health, eyesight and life of our citizens. Furthermore, I am reliably informed that our harmless and effective denatured alcohol can be put on the market as cheaply as Columbian spirits, Cologne spirits, eagle spirits or any other variety of "deodorized" wood alcohol. Practically, deodorized wood alcohol is a dangerous and virulent poison masquerading as a useful and comparatively innocuous household agent, pretending to be "just as good as" grain alcohol. As a matter of fact, it lies in wait to destroy the eyesight, perhaps the life, of those who use it.

As before stated, ar effective plan for driving out of the market the poisonous wood alcohol and its deodorized derivatives is to remove all the objections, mostly begotten of ignorance, to the use of "denatured grain alcohol" in the arts and trades, and by the public generally.

In a necessarily limited and imperfect fashion I have been carrying on an investigation of the reasons why our people have not fully taken advantage of "denatured" alcohol instead of using the deleterious wood alcohol and I find that apart from the fact that it takes time to displace an article to which the public has been long accustomed, the dangers of using wood alcohol are as yet imperfectly understood, even by those who habitually employ some form of alcohol in their business. I refer not only to the family use (in small quantities) for fuel and for cleaning, and to the painter and varnisher, but to the larger consumption of wood alcohol in the arts and sciences —to the paint, soap, varnish, piano, whip, drug, gunpowder, hat and other manufacturers—who ought to be fully acquainted with the poisonous qualities of the one agent and the harmless character of the other. I find that there are objections—technical and other—to the employment by some of the trades and manufactories of "denatured" alcohol as a substitute for methyl spirits. So far as my investigations have gone these objections can and ought to be removed.

The bill that established denatured alcohol provided for a denaturant that might vary with the needs of various arts and trades. In Germany, denaturization is "complete" or "incomplete" (*The Automobile*, Oct. 26, 1906), according to the purpose for which the spirit is to be used. "Complete denaturization is accomplished by adding to every 100 liters (26½ gallons) of alcohol 2½ liters of 'standard denaturizer' made of 4 parts of wood alcohol, 1 part of pyridin (a nitrogenous base obtained by distilling bone oil or coal tar), and 50 grains to each liter of oil of rosemary or lavender. A slightly different method consists of adding to every 100 liters of alcohol 1¼ liter of the 'standard denaturizer' and two liters of benzol. During the year 1903-4 a total of 26,080,505 gallons of alcohol denaturized by these processes were used for heating, lighting and commercial purposes in Germany.

"Incomplete denaturization is employed where the alcohol is to be used for special purposes for which the completely denaturized spirit would be unsuitable. The process is such as to render the spirit unfit for drinking, and varies according to the purpose for which the spirit is to be employed. For instance, for the manufacture of varnishes and inks, the alcohol is denaturized by the addition of oil of turpentine or of animal oil.

"Alcohol for the manufacture of soda soaps is denaturized with castor oil. Denaturized alcohol is used in the manufacture of celluloid and pegamoid. Alcohol for the manufacture of ethers, aldehyde, argacin, white lead, bromo-silver, gelatins, photographic papers and plates, electrode plates, collodion, salicylate acid and salts, aniline chemistry, and for a great number of other purposes, is denaturized by the addition of sulphuric ether, benzol, oil of turpentine, or animal oil."

In view of the facts just related I would suggest that your committee authorize this subcommittee to make a further investigation of the subject; (1) to inquire of those most competent to inform us the reasons for the partial failure to accept "denatured" alcohol as a substitute for the poisonous product, (2) to devise ways and means for the removal of the obstacles to the general use of "denatured alcohol," (3) to enforce the use of the poison label on all retail packages of wood alcohol, both impure and "deodorized", (4) to disseminate a wider knowledge of the poisonous character of every form of methyl alcohol, and (5), finally, to procure such legislative action as will prohibit the manufacture or sale of every form of "purified" or "deodorized" methyl alcohol.

All of which is respectfully submitted.

CASEY A. WOOD, Chairman.

REPORT OF THE SUBCOMMITTEE ON BLINDNESS FROM TRACHOMA

To the Committee on Prevention of Blindness:

Trachoma is a disease of great antiquity. We are assured by Hirschberg that it existed fully 3,000 years ago. Greek and Roman medical writings contain allusions to this disease and describe its blighting effect on vision. Cicero, Pliny and Horace are said to have been victims of the malady.

It is certain that the disease existed then, as now, in endemic form, in many localities, and, indeed, where the conditions were favorable, it overran entire countries, *e. g.*, Egypt. From Egypt it was imported into the continent of Europe early in the nineteenth century by Napoleon's soldiers and rapidly became disseminated. Wherever conditions were favorable, it gained a foothold and is to-day endemic in many localities.

Trachoma was brought to the United States by European immigrants coming from infected localities. It is, then, speaking from the standpoint of the United States, an "alien" disease.

RELATION OF TRACHOMA TO DEFECTIVE VISION AND BLINDNESS

The most frightful results of trachoma are to be seen in Egypt, where much the largest proportion of blindness is attributable to this cause. According to Snyder (*Ohio State Medical Journal*, March 15, 1909), 60 per cent. of all blindness in Europe is caused by trachoma. In Russia and the Baltic provinces, 96 per cent. of all trachoma patients become "more or less blind." Clark (Report on Trachoma, U. S. P. H. & M.-H. Ser., 1907) states that "75 per cent. of untreated cases of trachoma result in blindness." Even when the disease stops short of producing complete blindness, it seriously interferes with the workability of the eyes. J. W. Schereschewsky (Report on Trachoma, U. S. P. H. & M.-H. Ser., 1907), writing on this point says:

> It is astonishing to what degree slight alterations in the corneal tissues, as the result of trachoma, may reduce the sight. Even slight haziness may reduce the vision to one-tenth of normal. Pressure of the thickened lids and a macerating influence of the trachomatous secretions may so soften the corneal tissues and alter the corneal curvature that high degrees of irregular astigmatism, not susceptible to correction by glasses, are encountered.
>
> The menace to the vision in any untreated case is very real, even in cases initially mild, as subsequent exacerbations may induce a train of destructive corneal lesions. Trachoma decreases not only the economic efficiency of the sufferer, but that of the race or people as a whole, among whom it is prevalent. A person afflicted with trachoma is not on a par of productive capacity with a healthy individual. As the earning capacity of the victim decreases he must needs satisfy himself with a lower standard of existence, thereby not only exposing himself, but others who are dependent on his efforts, to those conditions of increasing poverty, filth and unhygienic surroundings which are known especially to foster the disease and to facilitate its distribution. In this manner the vicious circle is completed.

TRACHOMA IN THE UNITED STATES

Up to 1897, immigrants afflicted with trachoma were permitted to enter the country without let or hindrance. In this year, the disease was classed under the head of "dangerous contagions" by the United States Public Health and Marine-Hospital Service, thus making mandatory the deportation of aliens so afflicted under section 2 of the immigration laws. It was further specified that a steamship company permitting an immigrant with developed trachoma to embark must pay a fine of $100 and bear the expense of deportation. The steamship companies have learned by experience that it is not good business policy to book victims of trachoma and so have instituted a rigorous inspection of the eyes of all immigrants about to embark. At Italian ports, medical officers of the Public Health and Marine-Hospital Service are on duty and detect practically every case of trachoma among prospective immigrants.

The laws now operative seem adequate to prevent the entry of all but a small number of trachoma victims. It is impossible to say how many immigrants with trachoma were permitted to enter the country prior to the act of 1897, but judging from the number annually deported for this cause since the law went into effect, the former number must have been large. We may gain some idea of the probable annual importation of trachoma prior to 1897, by referring to the last (1910) annual report of the Commissioner-General of Immigration, which shows that 6,400 subjects of trachoma were debarred from embarking, 2,600 were debarred from landing and deported, and ten were deported having developed trachoma within three years of landing.

Prior to 1897 immigrants with trachoma, in common with their fellows not so afflicted, distributed themselves far and wide throughout the United States, some remaining in the port of arrival, others finding their way to inland cities, still others to rural communities of the west and south. Wherever conditions were favorable (bad housing, overcrowding, lack of ventilation, uncleanly habits), the disease, spreading from the original source, soon gained a foothold in the community. One frequently hears how "red-sore eyes" ran through a village school, scarcely sparing a single pupil. Or the invasion was more insidious until many, perhaps the majority, of people in a township were affected. Untreated, or inadequately treated, many of these unfortunates passed through all the wretched early stages of thickened lids, pannus, corneal ulceration, and finally, after years of suffering and partial industrial incapacity, emerged with scarred and incurved lids, nebulous corneas and greatly diminished vision.

LOCALITIES IN WHICH TRACHOMA IS KNOWN TO BE ENDEMIC

Many of the towns of southern Illinois are veritable hotbeds of trachoma. Northern Arkansas is seriously infected. The following excerpt from the twenty-first biennial report of the Arkansas School for the Blind indicates how serious is the menace to sight from trachoma in this state:

> The condition in Arkansas shows a larger proportion of pupils in school with trachoma than from all other causes, and a larger per cent. than is shown to exist in other states. The northeastern and northwestern portions of the state constitute the principal areas of infection. The eastern and southern portions are almost entirely free as far as shown by our records. In the Arkansas school the number of pupils enrolled, 1908-10, was 199 white and twenty-eight colored. The number of cases of trachoma and blindness caused from trachoma was 115. Careful investigations reveal the fact that there has never been a case of trachoma in the colored department in the twenty-two years of its existence.

The New Mexico Institute for the Blind reports that of fifty-eight new cases of blindness admitted within the last five years, 8 per cent. were blind from trachoma. The Connecticut School for the Blind reports that in the past five years thirty-three children were admitted to the school department, of which there were two known cases of defective sight from trachoma. Information on this point was sought from the blind schools of California, Georgia, Kentucky, Louisiana, Minnesota and Oregon in the hope that the figures obtained would be a fair index of the trachoma situation in widely separated parts of the country. At present writing (March 28, 1911) none of the above named schools has replied to my letter of inquiry.

Dr. J. A. Stucky, of Lexington, Ky., who recently made a journey into the heart of the mountain regions of eastern Kentucky, makes the following report:

> I found that in families where there were children it was an exception to find only one case of diseased eyes. In one instance seven out of the nine children were unable to attend school on account of trachoma. Such cases as these are not allowed to attend our schools, and yet in the mountains they are not considered infectious or dangerous, but just "sore" eyes. A solution to the problem in the mountains is the same as in the state—the question of education. Many of those who need surgical treatment and hospital care have not the financial means to obtain these. The county in which they live contains no institution where they can be cared for without personal expense and the county treasury contains no funds to provide for even the hospital care elsewhere.

EFFORTS, LEGISLATIVE AND SOCIAL, DIRECTED AGAINST TRACHOMA

Since 1905 Pennsylvania has classified trachoma with twenty-six other diseases as "contagious" and these are made reportable to the health authorities. In 1909, Philadelphia passed an ordinance requiring the reporting of all cases of trachoma, with residence and personal data of those affected, and the disinfection of a room or house which has harbored a trachoma patient. The city ophthalmologist visits the patient and advises the proper course to pursue. Since 1905, New York has maintained a "trachoma hospital" and two trachoma dispensaries.

The problem of the trachoma child is a serious one. Debarred by the inspector from school, he is in danger of losing all chance for education during the only years in which education is possible. London has met this problem in the schools by establishing the so-called trachoma homes under the auspices of the Metropolitan Asylums Board. These homes comprise a central administration building and separate houses under the charge of a house mother, each house lodging twelve children. Living thus under excellent hygienic conditions, and adequately treated by specialists, these children pursue their education without interruption during the period of cure.

The outlook for the city dweller afflicted with trachoma is none too brilliant. In ninety-nine cases out of one hundred, his economic condition is such that it is practically impossible for him to spare the time necessary to receive a prolonged course of treatment. But at least the city dweller with trachoma has the opportunity of skilful care. Not so his country-cousin, affected with the same disease. The latter, untreated, or improperly treated, by well-meaning but unskilled country practitioners, is almost always doomed to a long period of pain, wretchedness and partial industrial incapacity. By the time the disease has worn itself out vision is seriously impaired or entirely lost.

Many of our states, at least those in which trachoma is endemic, should follow the example of New York by establishing trachoma dispensaries in different parts of the commonwealth and a centrally located trachoma hospital.

Respectfully submitted,

JOHN GREEN, JR.

REPORT OF THE SUBCOMMITTEE ON CONGENITAL BLINDNESS

To the Committee on Prevention of Blindness:

Your Subcommittee on Congenital Blindness desires to make the following report, which should be received as only a partial, preliminary one. The subject is so vast, and the data are so scattered, that it has been possible to review the literature of only the last four years, viz., 1907 to 1910, inclusive, together with references contained therein to previous years. The facts collected have been arranged in the subjoined table, where the attempt is made to show graphically the different ocular lesions which justly may be called congenital. No condition is included unless the proof that it was congenital seemed sufficient. Only a brief abstract of the extensive literature is given.

From the statistics of Poland and Galicia, it is seen that from six to seven in every 10,000 inhabitants are blind. This agrees with Paly in regard to the blind of Switzerland (7.22 per 10,000). Out of 4,443 blind in Galicia, 1,057 cases were congenital (or 23 per cent.). In twenty-nine inmates of the Klarschen Blinden Anstalt, six (or 21 per cent.) were congenitally blind. These high percentages are found, however, only when the proportion of congenitally blind to blind patients is estimated. The ratio of congenital blindness to general ocular lesions is very much smaller. Out of 10,900 eye patients treated at Krain only thirty-four were congenitally blind. Out of 130,423 eye patients treated at thirty-two of the German, Austrian and Dutch eye clinics in 1907, only 610 were congenitally blind (about five to 1,000). Out of 159,313 patients treated at practically the same institutions in 1908, only 594 (about four to 1,000) were congenitally blind. So, it may be said that about 0.5 per cent. of all eye patients suffer from some form of congenital blindness, as shown in the table below. If the number of cases reported is taken as the standard by which to judge the relative frequency of each lesion's occurrence, the list will be headed by microphthalmos, followed closely by aniridia and by coloboma of the iris. Anophthalmos and the different forms of cataract also rank high. Most infrequent are the tumors, especially the teratomas.

In reviewing the lesions enumerated, it will be seen that they fall into two classes: (1) Those which, like medullated nerve-fibers in the retina, cyclopia, albinism, etc., are by their very nature congenital, and cannot be confused with postnatal diseases; (2) those in which only the history of an exact microscopic examination will allow the diagnosis of congenital or postnatal lesion, *e. g.*, cataract, dacryocystitis, staphyloma cornæ, etc. The latter class may be subdivided into two classes: (a) those where the element of time is the only distinguishing feature, *e. g.*, teratomata, staphyloma cornæ, etc., and (b) those where the fundamental lesion is the same but where the congenital varieties assume forms rarely seen arising postnatally, and where, consequently, the diagnosis of congenital can usually be made even when the patient is not seen immediately after birth, *e. g.*, lamellar cataract, colobomata, anophthalmos, etc.

The second fact to which it is desired to call attention is that, although these lesions have been classified as separate ones, it by no means follows that they are so found. On the

contrary, a congenital lesion of the eye is very frequently associated with other congenital lesions either of the eye or of some other organ. Mention might be made of the frequent association of microphthalmos with orbito-palpebral cysts, or of albinism with deafmutism. Coloboma of the chorioid frequently accompanies on the one hand coloboma of the iris, and on the other coloboma of the optic nerve. Mention has been made of atrophy of the optic nerve accompanying tower-skull. This is not a true congenital lesion of the optic nerve, but as the explanation has been given that the atrophy follows a congenital narrowing of the optic foramen with pressure on the nerve, it was included. With equal justice, the glaucoma which so often follows aniridia might have been included, since the initial stage of the glaucomatous status is frequently overlooked and may well be congenital.

No attempt will be made in this report to discuss the etiology of the congenital lesions, nor their tendency toward heredity. A special and very extensive report would be needed to do justice to these phases of the question. With these few preliminary remarks, a diagram of the congenital lesions of the eyes is herewith submitted.

CONGENITAL LESIONS OF THE EYE

A. Physiologic. B. Pathologic.

A. PHYSIOLOGIC

(a) Alexia. (b) Amblyopia. (c) Color Blindness.

B. PATHOLOGIC CONGENITAL LESIONS

I. LIDS:

(a) Ablepharia, (b) Insufficiency, (c) Coloboma, (d) Hypertrophy, (e) Epicanthus, (f) Symblepharon, (g) Ankylobleparon, (h) Blepharophimosis, (i) Dermal Oculopapebral Bridge, (j) Ectropion, (k) Entropion, (l) Albinismus Ciliarum, (m) Trichiasis, (n) Distichiasis, (o) Supernumerary Eyebrows, (p) Cyst, (q) Elephantiasis, (r) Angioma, (s) Nevus Pigmentosus, (t) Dermoid, (u) Neurofibroma.

II. LACRIMAL APPARATUS:

(a) Absence of Canaliculus, (b) Defective Development of Canaliculus, (c) Stenosis Nasal Duct, (d) Dacryocystitis.

III. CONJUNCTIVA:

(a) Protrusion of Conjunctival Sac Through Palpebral Orifice, (b) Ophthalmia, (c) Cyst, (d) Dermoid, (e) Lipodermoid, (f) Hemangioma, (g) Lymphangioma, (h) Pigmentation.

IV. EPISCLERAL TISSUE:

(a) Nevus, (b) Tumors.

V. BULBUS OCULI:

(a) Anophthalmus, (b) Cryptophthalmus, (c) Microphthalmus, (d) Buphthalmus, (e) Cyclopia, (f) Exophthalmus, (g) Cystic Degeneration, (h) Meningocele, (i) Coloboma, (j) Dermoid, (k) Lipochondroadenoma.

VI. CORNEA:

(a) Microcornea, (b) Megalocornea, (c) Staphyloma, (d) Sclerophthalmia, (e) Opacities, (f) Melanosis, (g) Defects Descemet's Membrane, (h) Dermoid, (i) Teratoma.

VII. SCLERA:

(a) Cyst, (b) Coloboma, (c) Pseudocoloboma, (d) Staphyloma, (e) Peripapillary Ectasia, (f) Negroid Sclerotica, (g) Cyanosis.

VIII. AQUEOUS CHAMBER:

(a) Movable Body, (b) Pigment.

IX. LENS:

(a) Ectopia Lentis, (b) Lenticonus, (c) Coloboma, (d) Pigment on Ant. Lens Capsule, (e) Complete Cataract, (f) Incomplete Cataract, (g) Anterior Polar Cataract, (h) Lamellar Cataract, (i) Posterior Polar Cataract, (j) Posterior Pyramidal Cataract, (k) Film-Like Cataract.

X. VITREOUS:

(a) Panophthalmitis, (b) Pseudoglioma, (c) Persistent Canal of Cloquet, (d) Persistent Hyaloid Artery, (e) Persistent Vitreal Vessels, (f) Persistent Vitreal Bands, (g) Teratoma.

XI. IRIS:

(a) Albinismus, (b) Heterochromia, (c) Ectropion Strati Pigmenti Iridis, (d) Coloboma Iridis Profundum, (e) Coloboma Stromæ Iridis, (f) Coloboma Iridis Totale, (g) Aniridia, (h) Pseudocoloboma, (i) Persistent Pupillary Membrane, (j) Corectopia, (k) Dyscoria, (l) Polycoria, (m) Atrophia Iridis, (n) Absence Sphincter Iridis, (o) Cyst, (p) Nevus.

XII. CORPUS CILIARE:

(a) Hypertrophy, (b) Cyclitis.

XIII. CHORIOID:

(a) Albinisms, (b) Ectropion Uveæ, (c) Coloboma, (d) Nevus.

XIV. RETINA:

(a) Albinismus, (b) Coloboma Pigmenti Retinæ, (c) Coloboma Retinæ, (d) Coloboma Maculæ, (e) Conus, (f) Ectasia, (g) Neuroepithelial Invagination, (h) Incomplete Development Outer Nuclear and Outer Reticular Layer, (i) Persistent Medullated Nerve Fibers, (j) Cyanosis Retinæ, (k) Hemorrhage.

XV. NERVUS OPTICUS:

(a) Aplasia, (b) Coloboma, (c) Coloboma Vagi, (d) Holes in Nerve, (e) Grooves, (f) Atrophy with Tower-Skull, (g) Hemorrhage, (h) Pigment, (i) Medullated Nerve Fibers.

XVI. MUSCLES AND NERVES:

(a) Hippus, (b) Ophthalmoplegia Interna, (c) Ophthalmoplegia Externa, (d) Nystagmus, (e) Strabismus, (f) Retraction Superior Rectus, (g) Abnormal Insertion Internal Rectus, (h) Defects of Abduction Associated with Retraction Globe, (i) Contraction of Eyelid in Association with Movements of Jaws, (j) Blepharospasm, (k) Retraction Levator Palpebræ, (l) Ptosis.

XVII. ORBITA:

(a) Exostosis, (b) Cyst, (c) Teratoma, (d) Dermoid, (e) Endothelioma Intravasculare, (f) Sarcoma, (g) Angiofibroma, (h) Angioma.

A. PHYSIOLOGIC

Though *Alexia* may be an acquired condition, it is also congenital. An interesting history is reported by Stephenson of six cases in one family. There is also a true amblyopia congenitalis, which v. Sicherer suggests may be caused by a previous unsuspected congenital retinal hemorrhage, which has been absorbed and has left no gross changes in the fundus. Whether color blindness is a true congenital lesion, or whether all children are color blind at birth, and this condition persists in certain individuals or groups of individuals, will probably never be decided.

B. PATHOLOGIC

I. LIDS: *Symblepharon* and *Dermal oculopalpebral bridge* might have been placed with greater justice under the heading of CONJUNCTIVA, while *Ptosis* could be considered a LID affection instead of being classed with the other NEUROMUSCULAR lesions. *Cysts* of the eyelids occur in either the upper or lower lid and very frequently accompany *Microphthalmus*. By *Entropion* is meant not the temporary form so frequently found in infants, but the permanent form requiring active measures for its relief.

II. LACRIMAL APPARATUS: The *Dacryocystitis* of the new-born is usually of postnasal origin. However, it may arise congenitally as Zentmayer and Fejér report. Mayou has written a very interesting paper describing the condition of the *nasal duct* in *lacrimal abscesses* of the new-born. It may be very small and partly occluded by the inferior turbinate, or it may be filled with débris at birth, or it may be non-patent or only partly so. The *canaliculus*, especially the lower one, may be absent or undeveloped.

III. CONJUNCTIVA: *Ophthalmia neonatorum* is not a true congenital affection, as the infection takes place usually during the act of delivery, and the inflammation does not appear until later. However, Rivaud-Landrau reports a case of *purulent ophthalmia* in the fetus, and there are doubtless many more reported.

IV. EPISCLERAL TISSUE: In reporting a case of primary epibulbar melano-sarcoma, Gross states that it developed from a congenital *pigmented nevus*.

V. BULBUS OCULI: The diagnosis of *Anophthalmus* should be made only after a very diligent search for a rudimentary eye, as the case is frequently one of *Cryptophthalmus*. The diagnosis of *Microphthalmus* is frequently made, when what is really meant is a rudimentary eye. *Buphthalmus* is sometimes used to refer to an enlargement of the entire eye and sometimes only to a condition of *megalocornea*. *Cyclopia* and *meningocele* are usually found in fetuses. *Exophthalmus* may be unilateral or bilateral.

VI. CORNEA: Peters reports an interesting *Defect in Descemet's membrane*. Collins in discussing *Staphyloma corneæ* claims that its etiology is the defective development of Descemet's membrane. Holloway gives a long review of the subject of *Melanosis corneæ*, while from the numerous histories of congenital *opacities of the cornea*, the case of McNab has been selected as at the same time illustrating the heredity of the lesion.

VII. SCLERA: The most interesting congenital lesions of the sclera are the pigmentation known as *Negroid sclerotics* and the *Cyanosis* of the sclera, caused by an abnormal thinness of the scleral wall, allowing the deeper, pigment layers to shine through. *Coloboma scleræ* is reported as *Coloboma oculi*.

VIII. AQUEOUS CHAMBER: As congenital anomalies, *Pigment masses* and a *Movable body* in the aqueous have been reported. However, every anomaly of size of the cornea is reflected in the depth of the anterior chamber.

IX. LENS: The literature dealing with congenital *Cataract* is very extensive. The following forms have been reported: *incomplete, complete, anterior polar, posterior polar, lamellar, posterior pyramidal* and a *film-like cataract*. Another fairly frequent lesion is *ectopia lentis*, where the lens may also be cataractous and shrunken, or a *coloboma* may be present.

X. VITREOUS: The most frequent congenital lesions affecting the vitreous are persistent remnants of fetal structures, such as the *Hyaloid artery* and the *Canal of Cloquet*. However, a case of *panophthalmitis* has been reported.

XI. IRIS: *Albinism* may show itself as part of a complete ocular albinism, or as a local condition. *Heterochromia* may be acquired, but is frequently a congenital condition. It varies in extent from a small sector in one eye to complete color differences in the two eyes. *Coloboma iridis* varies in extent from a deficiency of either the pigment layer or the stroma, to the total absence of a large sector of the iris. There may be a bridge of stroma across the coloboma. On the other hand, the loss of iridal tissue may be so great as to constitute a complete *aniridia*, or it may be so small as to be limited to an absence of the sphincter iridis. The pupil may be *ectopic, distorted* or *multiple*. The *polycoria* may take one of four forms according to Collins: (a) Normal pupil divided by a persistent pupillary membrane, (b) Coloboma with a bridge, (c) congenital iridodialysis, or (d) intact pupil, with iris openings not reaching ciliary margin. Numerous cases of *Persistent pupillary membrane* have been reported, each one assuming a different form from the others.

XII. CORPUS CILIARE: Only two congenital lesions of the ciliary body have been reported, viz., *hypertrophy* and *cyclitis*.

XIII. CHORIOID: The lesions of the chorioid may or may not accompany lesions of other structures, e. g., the iris, optic nerve or retina.

XIV. RETINA: *Medullated* nerve fibers may be found radiating from the disc, or isolated in the retina. *Colobomas* may vary from defect of the pigment to absence of all layers. Especially is this latter found in the *macula*. This may be the result of an intra-

uterine hemorrhage. *Cyanosis retinæ* due to engorged retinal vessels has been reported.

XV. NERVUS OPTICUS: *Coloboma* may involve the *sheath* alone or the *whole nerve*. It may be accompanied by a *conus*, or may take the form of a *hole* in the disc. *Grooves* of the disc have been reported, varying in size, shape and position. Congenital *pigmentation* of the disc is not so very rare, and may take varied appearances.

XVI. MUSCLES AND NERVES: There may be a complete or incomplete *ophthalmoplegia interna* or *externa*, though the incomplete external variety is the most common. *Ptosis* is especially frequent. *Nystagmus* also occurs frequently. A curious congenital anomaly is the *simultaneous movements of the upper lid and jaw*.

XVII. ORBITA: The congenital lesions of the orbit are *new growths, exostoses* or *cysts*.

Respectfully submitted,

CLARENCE LOEB.

REPORT OF THE SUBCOMMITTEE ON HYGIENE OF THE EYES

To the Committee on Prevention of Blindness:

In compliance with your request to organize a committee to study the effect of various forms of artificial illumination on the eye, I beg leave to report that such a committee has been formed and, after considerable deliberation, has decided on a definite plan of procedure. We have been most fortunate in obtaining the consent of a number of distinguished physicists and illuminating engineers to serve on the committee and an agreement has about been consummated with the Illuminating Engineering Society whereby we will have the full cooperation of this large and powerful organization.

Several of the large electric lighting and gas illuminating companies have also manifested their willingness to give us whatever aid we may desire, so that it is the opinion of your chairman, that the investigations which the committee will carry on promise to be productive of most excellent results.

After considerable discussion, it has been decided that the first investigations should be along practical lines, and our plans are as follows: The physicists and engineers on the committee will determine on a number of standard lights, that is to say they will furnish the ophthalmologists with some four or six sets of gas and electric lights, of which they have ascertained all the physical characteristics. These lights will then be installed in large rooms where a considerable number of people, a hundred or more, are engaged in some form of labor which requires prolonged and accurate use of the eyes. It shall then be the duty of the ophthalmologists on the committee to make a careful test of the eyes of all those who will be subjected to each form of illumination, both before the trial begins, and a second test some months later. The ophthalmologists will employ all the tests which are in common use in the functional examination of the eyes and in addition, a number of other tests which the physicists and physiologists on the committee will suggest to them.

It is the intention to exhibit the standard lights in a variety of ways, so that some idea may be obtained of the effect of the so-called direct and indirect forms of illumination.

By experimenting with a large number of subjects and noting the average result, it is thought that more valuable and accurate deductions will be obtained, than if the effect of the various forms of illumination was studied on the eyes of single individuals.

It is not the intent of the committee at this time to concern itself with the question of school hygiene, but it is hoped that the investigations may develop much which may be of value in that important subject. The committee is therefore desirous of keeping in touch with the committee from the National Educational Association which is making observations along these lines and wishes to assure that organization of full cooperation.

The actual work of investigation will begin early in the autumn, as it is hoped by that time that the scientists on the committee will have determined on the standards which they desire to have tested.

The committee consists of:

Dr. Louis Bell, 120 Boyleston Street, Boston.
Percy W. Cobb, National Lamp Association, Cleveland.
Mr. E. L. Elliott, Illuminating Engineering Pub. Co., 15 West Thirty-Eighth Street, New York.
Prof. Arthur W. Goodspeed, University of Pennsylvania, Philadelphia.
Dr. George Ross Green, 1000 Chestnut Street, Philadelphia.
Dr. Herbert E. Ives, 4503 Hough Avenue, N.-E., Cleveland.
Dr. Edward Jackson, 1434 Glenarm Place, Denver.
Mr. Preston S. Millar, 29 West Thirty-Ninth Street, New York.
Mr. Charles F. Scott, Westinghouse Electric and Mfg. Co., Pittsburg.
Dr. William Sweet, 1205 Spruce Street, Philadelphia.

Respectfully submitted,

WILLIAM CAMPBELL POSEY, Chairman.
CHARLES O. BOND, Secretary.

REPORT OF THE SUBCOMMITTEE ON INDUSTRIAL CONDITIONS

To the Committee on Prevention of Blindness:

Space forbids a comprehensive consideration of this broad subject. A complete catalogue of the various trades and industries in which accidents, even preventable accidents, causing partial or complete blindness of one or both eyes, although suggestive, would be of little service and would necessarily include nearly all the causes of accidents in general. Consideration will therefore be limited to the following:

1. Common accidents to the eye in foundries, machine shops, mills, and in the building trades, domestic, agricultural and military pursuits, which can be greatly prevented by various known means, as in iron workers, mechanics or weavers.

2. Accidents occurring while handling high explosives as in clay manufacturing, quarrying, mining and railroad construction.

3. Accidents due to bursting of locomotive oil and water gauges, bottles and syphons in bottling.

4. Accidents due to scalds or caustics or exposure to irritating gases and fumes as from hot fluids, molten metals, lime, corrosive acids or alkalis entering the eye-sac.

5. Diseases due to excessive light or heat, e. g., in electric welders, steel smelters, and in those melting or annealing glass.

6. Diseases due to working in certain poisonous gases and fumes, dusts or substances, bisulphids of carbon, lead, etc.

7. Diseases due to occupations requiring prolonged and peculiar use of the eyes, e. g., nystagmus in miners.

1. COMMON ACCIDENTS IN MILLS, TRADES, ETC., WHICH CAN BE GREATLY PREVENTED

These include blows from blunt force and wounds of all description, incised, punched, lacerated and contused, occurring from the use of tools or caused by foreign bodies of all kinds, magnetic or non-magnetic, retained or not within the eye. Ordinary domestic injuries, in addition to the above, include scratches of the conjunctiva or cornea and wounds from knives, scissors, forks, useless air guns, fireworks, improperly carried umbrellas, etc.

Blows from blunt objects on the eye or its surroundings may cause ecchymoses and swelling of the lids, fractures of the orbit, ecchymoses and hematomata of the conjunctiva or orbit, rupture, concussion or dislocation of the eye-ball, rupture or paralysis of the muscles, rupture of or pressure on the optic nerve by hematomas, aneurysms or fractured bones. In addition the iris may be torn, the lens dislocated and the various structures within the eye injured. The base of the skull may be fractured and traumatic exophthalmos or the pulsating variety result.

Small particles are very likely to become lodged in the cornea of workmen of various trades, especially of the iron and steel trades. This is very common in the eyes of grinders, especially dry grinders who do not use a wet stone, small particles of the metal being ground off the stone or emery wheel used. Close examination with a magnifying glass or loupe of the cornea, often peculiarly insensitive, will usually show large numbers of minute scars, sometimes so numerous as to dull the cornea and affect the vision. Fans, making air currents, so as to pull or blow the particles away from the eyes are very important in many trades, also to prevent the inhalation of foreign particles or various noxious gases, thus securing better ventilation and benefiting the general health. Various shield devices, solid and adjustable, are now on the market. They are very generally used by the United States Steel Company and are exhibited in the American Museum of Safety in New York of which Dr. Tolman is in charge. These shields are placed on grinding wheels, circular saws, lathes and many forms of rapidly revolving machinery, helping to prevent particles flying into the workman's face and are a safeguard against accidents in case the revolving parts should break. Recently much has been done to prevent revolving wheels, etc., from breaking by the use of proper compressible washers, larger than the flanges, making proper application and distribution of pressure to a large space on the side of the straight-sided wheels. The flanges are more than one-half the diameter of the wheel and bear only at their circumference on a flat surface. The caliper rest is adjusted as close to the wheel as possible, lessening the danger of the material being caught between the wheel and the rest. Large protecting glasses or the worker's own lenses, if he requires any, are also of much service in preventing particles getting into the eyes, as well as for saving the eyes from more dangerous accidents from large flying particles. Glass protectors are also made surrounded by wire gauze as in goggles. Unfortunately

they get dirty and marked with the frequent blows from flying particles so that the workmen, unwilling to accept such pressing testimony of their use, too often lay them aside.

Injuries from these small flying particles may be slight or serious. Sometimes small particles puncture the coats of the eye-ball and unless removed, especially if metal, endanger both eyes by causing sympathetic inflammation, which according to Magnus is the cause of from 4 to 4.5 per cent. of total blindness. In some cases infection results, giving rise to dangerous ulcers which sometimes destroy partially or wholly the eyesight or even the eye-ball. Serious accidents to other parts of a workman or even other workmen sometimes occur because an operator getting something into his eyes cannot see sufficiently to manage machinery. The opportunities for slight or severe eye injuries in iron and steel workers are multitudinous and occur in all branches of the work, light or heavy.

Many of these accidents occur in chipping, fettling or dressing rough edges of castings, ingots and even large armor plates. These chippings are very brittle and sharp and fly about, often bounding from objects which they strike. They are caused by one or two strikers hitting a chisel held against the offending part by another man. Not only particles are likely to fly from the metal struck but from either end of the chisel or from the hammers of the strikers. S. C. Ayers pointed out that cheap hammers and chisels of poor quality are frequent causes of eye accidents in mechanics. Care is taken in some shops to examine carefully and regularly these tools to prevent accidents. Pneumatic chippers are safer. Passersby and other workers may be protected by chiseling against a wall or a screen covered with canvas or burlap which will hold the flying particles and not reflect them. Brick cleaners should take similar precautions.

Burning sparks and flashes are common from molten metal running into molds, in great or small forgings, by hand, steam or hydraulic hammers. When there is great heat glass protectors to the eyes are of little service, but good safe protectors of wire gauze covering both eyes and face, especially those with asbestos over mouth and neck, are useful. Rusting may be provided against by making the frames of galvanized iron or aluminum wire.

Coal miners are likely to be injured by small particles of coal or splinters from the pick point becoming embedded in the cornea, abrading its surface or cutting it. Such injuries are particularly likely to become septic. Agriculturists often meet with eye accidents in threshing, chaff cutting, hedging, in distributing artificial fertilizers and by the entrance into the eye of spears of grains and grasses, twigs and leaves, also from insects and their stings. These injuries are usually produced by vegetable substances, straw, beards of wheat, etc., and are likely to become infected. Cowhorns, claws and kicks from animals cause many accidents. Special forms of affection result in taking care of some plants, as ophthalmia among hop pickers, due to entrance of fine, thin hairy-like processes from the hop leaves. Dusty labor is likely to cause troublesome eye conditions, as in sawmills from flying sawdust and knots, at threshings, in handling coal and ashes, in flour mills and from fine particles of copper off trolleys, but the eyes can be greatly protected by proper goggles.

Stone masons, grindstone makers, quarrymen, bricklayers and stonebreakers can partially protect their own eyes by proper protectors and should be more careful to dress their work against some wall where passersby will not be so likely to be injured. Wire drawing where great tension is placed on the wire causes accidents from breaking or slipping of the wire which backlashes and may strike some one. In weaving there is great danger of a flying shuttle striking the eye but many patterns of guards are now on the market to prevent this. Some are known as wing guards, consisting of a wire screen or canvas placed between the looms, others provide means to prevent the shuttle from rising. The military man and sportsman are subjected to the danger of small and large shot and bullets, shell explosions, sword and bayonet injuries and explosions of various kinds.

There are various processes involving exposure to irritating dusts, as to the dust of graphite in the manufacture of stove polish, bronze powder, while bronzing in lithographing, in all processes of grinding, glazing or polishing, and while talc (soapstone) dusting in rubber manufacturing. In sorting, dusting, cutting or grinding rags, and in cutting, boring, turning, planing, facing, doming, grinding or polishing pearl shell, dust is also likely to get into the eyes. Everywhere in the air volcanic and meteoric dust is present, the latter consisting of tiny spherical shot-like pellets, 1/200-1/500 of an inch in diameter. The flinty shells of diatoms, tiny plants, and dust from sandstones and deserts often get into the eyes. The pollen of plants as from pine trees, scales from the wings of butterflies and other insects, really hairs as from caterpillars, also get into the eyes.

2. ACCIDENTS WHILE HANDLING HIGH EXPLOSIVES AS IN QUARRYING, MINING AND RAILROAD CONSTRUCTION

Blasting in mining, quarrying, etc., causes a large number of accidental injuries. These accidents are particularly likely to destroy both eyes, removing the earning capacity of the individual and possibly throwing him on the community for support. Powder grains are often embedded in the eye-balls, lids or face. Most high explosives unlike gunpowder are not exploded by simple ignition but require an exploder. Poor fuses or explosives, possibly frozen, with improper loading cause premature blasts or misfires. Accidents usually occur from drilling these "missed holes," striking an unexploded piece of explosive or cap packing with a metal instead of a wooden tamping rod, carelessness with cigar ashes, hot candle grease or in handling the explosives. Donovan (THE JOURNAL A. M. A., Aug. 5, 1905) states that blasting injuries with few exceptions result from want of care on the part of the patient, his associates or his predecessors at work. Large quantities of explosives, whether solids, liquids or gases, should not be stored in any one place especially in thickly settled communities. Greater care in proper insulation of electric wiring in such regions and the prevention of the possibility of sparks by short circuiting should be observed. Licensing of "powder men" and better government inspection of the manufacture, storage and sale of explosives would be helpful.

3. ACCIDENTS DUE TO BURSTING OF WATER GAUGES, BOTTLES AND SYPHONS IN BOTTLING

Gauges on every description of steam boiler frequently break, injuring by flying pieces of glass, or scalding by the steam or hot water. The slowly soluble gauges are worn by the friction of the moving fluids within and may be protected by surrounding them with wire netting or plate glass protectors open at the back so that the direction of an explosion may be controlled. The chief danger comes when putting in a new glass after one is broken. On turning the hot water into the cool glass it suddenly breaks. The United States Steel Co. has swinging wire protectors that may be placed in front of these gauges until the glass has been warmed and tried when the protector is swung out of the way so that the gauge can be more readily seen by the engineer at a distance. These accidents occurring to engineers who require a high degree of visual acuity greatly lessen their earning capacity and at the time of the accident may endanger many lives and much valuable property.

In the manufacture of aerated waters and in bottling beverages of nearly all kinds, the frequent bursting of bottles and syphons is very dangerous to the eyes. The bottles are cleaned, filled, corked and wired by machinery and in all the various processes and inspections which are necessary, there is danger of the bottles bursting. The dangerous trades committee of England, 1896, recommended that all bottlers, wirers, sighters and labelers while at work should be provided with face guards, masks or veils of wire gauze. They also recommended the providing of gauntlets for the arms and the fencing with wire gauze of all machines for bottling, to prevent fragments of bursting bottles striking any workers.

4. ACCIDENTS DUE TO SCALDS OR CAUSTICS OR EXPOSURE TO IRRITATING GASES AND FUMES

Scalds or burns usually involve the eyelids, the deeper burns affecting the eye generally resulting from explosions as in preventable Fourth of July accidents. Powder burns should be treated with hydrogen peroxid, afterward applying 5 per cent. boric or other simple ointment. Powder grains or other foreign bodies in the cornea require the use of a local anesthetic and spud. Burns in masons, plasterers and bricklayers caused by lime, especially unslaked lime, CaO, sometimes result in destruction of the cornea and frequently in traumatic pterygia and adhesions between the eyelids and globe and, because of chemical combination with substances in the cornea, produce permanent opacities. When unslaked lime gets into the eye it should be wiped out by a dry clean cloth or washed out with liquid petrolatum, castor or olive oil. If this is not done at once the lime will soon be slaked by the tears and then large quantities of water can be used to help remove it. Besides causing actual destruction, lime and cement have irritating qualities sometimes occasioning conjunctivitis and even ulceration of the cornea with loss of vision in those who work constantly with these substances. There are also various caustics

employed as in the manufacture of chemicals, alkalies and acids. Proper, clearly worded signs giving warning of the dangers from careless handling of caustics in shops and schools, would lead to greater care being exercised. In accidents caused by unslaked lime and certain corrosive fumes, workmen should pour liquid petrolatum, olive or even castor oil (quantities of which should be kept handy in certain trades) into the eye. Ammonia burns should be treated immediately by profuse irrigations with water according to Pichler. (Cauterization of the Eye and Epidermis by Ammonia, *Zeitschr. f. Augenh.*, April, 1910, xxiii, 297.) For workmen compelled to use certain acids or alkalies proper neutralizing washes should be supplied so that fellow workmen, properly instructed, may use them at once. After burns of the cornea by acids, H. Guillery ("Chemical and Clinical Investigations on Cauterization of the Cornea," *Archiv für Augenheilkunde*, lxv, 139) advises bathing the eyes with 0.5 per cent. solution of hydrate of potash and claims that the opacities from lime may be partially cleared by the use of a 10 per cent. solution of chlorate of ammonia with 0.1 per cent. tartaric acid. For lime burns Würdemann advises copious washings with cold water and the use of 3 to 10 per cent. solution of ammonia chlorid, the calcium being dissolved and carried away. Any mildly acid solution may be used for recent burns with alkalies. H. Schmidt asserts that corneal burns from acids are likely to cause opacities of the lens. (*Zeitschrift f. Augenh.*, March, 1910, xxiii, 341). Exposure to irritating gases and fumes takes place chiefly in gassing in textile factories, singeing in print works, in bleaching and dyeing works and in dipping metals in acid solutions.

5. DISEASES DUE TO EXCESSIVE LIGHT OR HEAT, E. G., IN ELECTRIC WELDERS, STEEL SMELTERS AND IN THOSE MELTING OR ANNEALING GLASS

Metal polishers and buffers brightening surfaces, which they must closely watch, often suffer with hyperesthesia of the retina. This can be relieved by proper lenses or colored glasses. Excessive heat and light are met with in iron and steel works. Men can watch a furnace until the temperature is up to 2,000 F. but before it gets to 3,000 F. colored glasses should be worn. In working with cast iron, 1,800-2,000 F., the men take few precautions; with molten metal, 2,700-2,800 F., deep blue glasses are necessary. With Bessemer metal, 3,000-3,200 F., the process is completed in about twenty minutes and only one man needs to watch the metal which he does with a spectroscope about thirty feet distant. The Siemons process takes ten hours and all the men, wearing colored lenses, make observations frequently. If some of these hot furnaces are looked into without lenses it is several minutes before the eye can see ordinary objects again. Some men seem to have surprising immunity from bad results in dealing with these white hot furnaces, others cannot endure them and must change their work. Snell doubts the greater frequency of cataract in glass blowers and iron workers than in others, although both are subjected to great heat and consequent loss of moisture. Herbert Parsons and Marcus Gunn in 1908 visited some of the important glass works in England to gather statistics of industrial diseases for the framing of the Workmen's Compensation Act. They state that bottle makers have a characteristic form of cataract, typically, a dense well defined disk of opacity in the center of the posterior cortex. Often slight opacities surround this posterior cortical disk. Excessive heat and bright light are said to be the causes but the Germans claim that heat is the most important cause. Weyl mentions, besides glass blowers, fire workers, puddlers, blacksmiths, bakers and cooks.

Great care is required to avoid very strong light flashes before the eyes as in short circuits and electric welding. In the latter large shields are worn in the center of which are four alternate layers of blue and red glass. Helmets and screens with four or six layers of red and green glass are often used. The temperature in electric welding goes as high as 7,000 F., but the question of whether it is the heat or the chemical rays that act so harmfully has not been settled. If the eyes catch the light they are affected at once but chiefly some hours after. They feel swollen as if filled with burning sand and the pain is usually very severe, the lids are swollen and there is much lacrimation. Intense light as from electric and vapor lamps, from exposure to snow or after observing an eclipse, frequently causes a superficial ophthalmia and may affect the lens and retina. Schanz and Stockhausen found that the superficial irritation could be prevented by a screen of Euphos glass which absorbs ultra-violet rays. W. H. McMullen (*Ophthalmic Review*, April, 1910) claims that this could be done with plain glass which absorbs rays of wave length less than 300 mikrons. He thinks opacities in the lens result when the wave lengths are between 300 or 400 mikrons but that the rays of greater length as well as the short cause the retinal changes. Würdemann states that electric light flashes or lightning may cause cataract and by being focused on the macula destroy the central retinal elements.

6. DISEASES DUE TO WORKING IN POISONOUS GASES AND FUMES, DUSTS OR SUBSTANCES

Dinitro-benzol is largely employed in making explosives. During the various processes of its manufacture fumes are given off which affect vision. These can be lessened by properly covering the mixtures and by the use of fans and exhaust apparatus. Respirators and glasses are used. The general circulatory and nervous effects are fully described by Snell (*British Medical Journal*, Vol. i, 1892) and he outlines many excellent suggestions for preventing deleterious effects in manufacturing this substance. Bisulphid of carbon, formerly much used in vulcanizing rubber, caused impaired eyesight but this process has been so greatly modified that it is now of little importance in causing ocular lesions. Toxic amblyopias due to tobacco, ethyl alcohol and wood alcohol are to be considered by my associates on this committee.

The eye affections formerly attending the manufacture of iodoform have by care been eliminated. A few cases of eye involvement have been reported in dye factories from handling the various coal tar preparations. Arsenic from wall paper, artificial flowers and paris green, paper hangings and paintings, also when used for medical or cosmetic purposes, according to Casey Wood has caused various visual disturbances. Painters, plumbers, electrotypers, filecutters and many others, through handling lead, are likely to get chronic lead-poisoning causing central and peripheral affections of sight, various paralyses, retrobular neuritis, etc. Lead-poisoning is also found among those manufacturing white, yellow, orange and red lead, lead pipe, solder and plumbers' supplies and in cutting metal articles composed of lead or lead and tin; in grinding lead paint, making storage batteries, cleaning or handling printing type and in glazing in pottery establishments. Poisonous gases and fumes are found in shoe cement, japanned or patent leather and rubber manufacturing where the mixtures containing naphtha are sometimes allowed to remain in uncovered containers and proper ventilation is not insisted on. Poisonous gases are also formed in certain lead processes.

7. DISEASES DUE TO OCCUPATIONS REQUIRING PROLONGED AND PECULIAR USE OF THE EYES

Nystagmus in miners, due to their peculiar way of looking at their work, is fully described by Snell. He states that treatment consists in changing the kind of work. After relief the miner can return to his work if the head can be kept straight and the eyes are not often turned upward. Snell mentions several other occupations which he has thought might cause nystagmus.

PROPHYLACTIC MEASURES

In the effort to decrease blindness from industrial accidents the following considerations should be kept in mind:

A. The importance of prompt and skilful first aid and means by which it can be secured.

B. The more general use of well known aids to the physician, hospital, Roentgen ray, proper antiseptics, etc.

C. Why the public should be interested.

D. How to secure the cooperation of the employer in the prevention of accidents and diseased conditions arising in the various industries.

E. How to interest and secure the active cooperation of the employee in the same cause or crusade.

A. THE IMPORTANCE OF PROMPT AND SKILFUL FIRST AID AND HOW IT CAN BE SECURED

The importance of prompt and skilful first aid can scarcely be realized by those who do not treat many injured eyes. In factories and work shops, especially in the iron and steel industries, small particles of iron, emery or other stone very frequently strike and become embedded in the cornea. This is so frequent that the corneæ of many of these workmen studded with small scars, more or less reducing visual acuity, especially if located in the central zone, acquire a certain degree of insensitiveness. The workman's usually quick recovery begets carelessness and fellow workmen without any knowledge of necessary surgical cleanliness, but nevertheless with a certain skill, remove the offending foreign body. This is done with dirty hands decorated with unclean finger nails and by filthy crude instruments, such as a foul handkerchief or toothpick possibly removed from a never germ free mouth, blade of a pocket knife, blunt lancet, pin, tongue, etc. Snell found many

of these instruments were free from dangerous infections. The wonder is that more infectious ulcers do not occur, but the foreign bodies are frequently sterilized by heat before entering the eye-sac. The improper use of poultices and of flax seed or eye stones destroys many eyes. Without the proper use of local anesthetics, good control of light and magnifying loupe, the removal of the small and more deeply embedded particles, sometimes projecting into the anterior chamber, is attended with great difficulty and danger; the eye not being easily controlled or seen, much precious tissue is often unnecessarily scraped away in futile efforts to dislodge the offending particle. No antiseptic is employed to weaken or destroy at least partially the infectious germs, often carried into the eye by the foreign body, and no eye-wash is supplied to secure greater cleanliness afterward. Ophthalmias, iritis, infected ulcers, with resulting scars, partial or total blindness and even loss of the eye and sometimes of the fellow eye occasionally follow such unskilled attempts to remove simple foreign bodies. When the eye-ball has been punctured, especially if the eye-sac has already been infected from a tear-sac infection or other cause, infections of the interior of the eye will frequently result without early trained attendance.

Snell supplied some of the more expert workmen in Sheffield with iridium-platinum bent pointed spuds the points of which are sterilized in the flame of a spirit lamp before use. No one but a surgeon or trained nurse, however, can understand the details of keeping an instrument clean, presuming that it was clean to begin with. The loss of time due to unnecessarily severe inflammations, the impaired usefulness of valuable employees has brought about the rule in several shops, that no workman shall attempt to remove foreign bodies from the eyes of fellow workmen, and that employees so injured shall be sent to a competent surgeon at once. First aid before the surgeon can be secured usually should be limited to the early use of oils or neutralizing washes after burns from lime or chemicals and to covering the injured eye with clean cloths or gauze. In some trades where certain forms of accidents are common the surgeon, with advantage, could train some one in the proper use of cold applications to help prevent infections.

B. THE MORE GENERAL USE OF WELL-KNOWN AIDS TO THE PHYSICIAN, ROENTGEN RAYS, PROPER ANTISEPTICS, HOSPITAL, ETC.

A trained ophthalmologist will often find his whole skill and knowledge put to the test in caring for eye injuries, and it is unnecessary and impossible to outline methods for caring for so many different conditions. The treatment of ocular traumatisms is based on general surgical principles and may consist in removal of foreign bodies, cleansing and coaptation of the edges of the wound, the use of proper occlusive bandages, special operations as iridectomies, protection by sliding conjunctival flaps, atropin to retract the iris and quiet the ciliary muscle, dionin to relieve pain and hasten absorption, cold applications to prevent infection and hot to assist absorption of exudates. The prevention of infection in operations and care that injuries are not done to other structures as the lens in doing an iridectomy are important. The use of antiseptic ointments and subconjunctival injections are often advisable. The interests of the patient and the possible liability of the employer often demand a careful and full history of the accident and subsequent care, also a guarded prognosis, as so much depends on previous conditions possibly due to former injuries. In all cases after removal of an imbedded foreign body and in most cases where a foreign body has even become lodged under the lids, depending on the probability of an infection and its nature, I drop one drop of a 1 or 2, and rarely 3 gr., to the ounce silver nitrate solution in the eye-sac. A mild-unirritating alkaline antiseptic wash with an eye-bath and proper directions as to use are nearly always supplied. Where ulceration or iritis has already commenced mydriatics, cathartics, etc., are also prescribed. Rest should often be secured by bandages and cycloplegics and sometimes by the use of antispasmodics and hypnotics.

Roentgen ray negatives, as a means of determining the presence and location of a foreign body, except wood or other vegetable matter, in the eye-ball, sooner or later dangerous to one or both eyes, are very valuable. Magnets, large and small, are often necessary for the removal of magnetizable foreign bodies. The safety of their use for diagnosis is questionable, no anesthetic in such cases should be used as pain is a valuable sign. The current should be turned on and off with the magnet at a safe distance from the eye. Non-magnetizable foreign bodies are becoming more frequent with the increasing use of magnesium and nickel steel and the more common use of copper and other non-magnetizable substances. Sweet (*Ophth. Record*, October, 1909) states that the loss of eyes injured by foreign bodies depends not only on the size of the piece but greatly on the length of the period elapsing between the injury and removal. It is safer to learn the position, shape and size of the foreign body before determining to remove it through the original wound, if recent, or through an opening in the sclera. For the detection of injuries and foreign bodies stains with aniline dyes, as 2 per cent. fluorescin, focal illumination, magnifying loupe, ophthalmoscope, Würdemann's diaphanoscope and, except in large cities and in the neighborhood of electric currents or where there is much vibration, the sideroscope, are useful. Many firms are now establishing first aid dispensaries with a trained nurse in charge and depending on the size, nature and enthusiasm of the firm, this develops into a temporary hospital ward or even a hospital, where other hospital facilities are not accessible. Physicians are in attendance at these hospitals during certain hours when treatment and dressings are made by physician and nurse.

C. WHY THE PUBLIC SHOULD BE INTERESTED

Lans states that of all accidents in the Netherlands, 1903 to 1904, 4 per cent. were on the eye. Mr. Watson, secretary of the British Miner's Benefit Fund, ("Dangerous Trades," Thomas Oliver) gives the total of 2,506 eye accidents out of a total of 48,262, a percentage of 5.19. The percentage of eye accidents would naturally be greatest in populous industrial districts and among men. Snell states that of 2,554 patients who passed through the wards of the Sheffield Royal Infirmary 2,038 were men and 516 women; of the men, 622 or 30.52 per cent. were admitted for accidents; of the 516 women only 6.9 per cent. were for accidents. According to Würdemann (H. V. Würdemann, "Injuries to the Eye and Adnexa," *Northwest Medicine*, February, 1909) Frieuzal found 9.8 per cent. of blindness due to injuries; Trousseau, 16.32 per cent.; Magnus, 10.76 per cent.; Fuchs, 7.9 per cent. In 1900 of 75,568,686 inhabitants in this country there were 64,763 blind; 35,645 totally blind; 4,462 totally, 2,226 partially blind (a total of 10.33 per cent.) from injuries, accidents and operations. This was a decrease of 586 from the 1890 figures although the population had increased 12,944,436. E. L. Elliott believes there are 20,000 more or less serious injuries to the eyes of workmen through accidents, chiefly preventable, in this country each year. F. W. Miller (THE JOURNAL A. M. A., Aug. 5, 1905) states that ocular traumatisms are becoming more frequent with the increase of mechanical appliances, rapid transit, etc., and the more general use of chemicals and gases. On the other hand, according to census figures the frequency of blindness due to accidents is becoming less, due partially to the more general use of safeguards against accidents, especially industrial accidents, and partly to the better management and care which these cases now receive. Würdemann states that a loss of 20 per cent. of visual acuity in the higher trades and 50 per cent. in the lower materially lessens the earning ability, the ratio being decreased in arithmetic proportion until the individual is incapable of earning anything, becoming a charge on the family or community. The young blind may be taught to substitute partially the other senses for eyesight, but the adult suddenly becoming blind finds this difficult and often impossible. Arbitrary legal rules, accident insurance companies, the United States Pension Office and the indemnity laws of England, France, Germany and other countries consider the total loss of eyesight equal to the loss of life. The loss from total blindness of one eye or of partial blindness of one or both depends on many factors, but scientific examination and calculation have determined the effect of a certain loss of vision on earning ability. Insurance will demand greater care to eliminate the unscrupulous who simulate eye disease or exaggerate it, and therefore entrance and periodic examination of the visual acuity of workmen will be made necessary. Persons with only one good eye would be damaged more in proportion where it was lost than where a good eye remained, especially if the vision of the damaged eye had been subnormal before the accident. Lans ("Traumatic Affections of the Eye," *Tydschr. V. Gen.*, December, 1908) collected statistics of the earning capacity of fifty consecutive patients with monocular blindness from accident. Of this number two earned constantly less through change of work, two temporarily less, thirty-eight as much as before accident and eight, more. The public therefore should be greatly interested in the prevention of blindness from industrial accidents, not only from a sentimental or humanitarian standpoint but from an economic one as well. Partial or total reduction of vision lessens efficiency and therefore makes many victims a charge on society. Great sums of money are expended in teaching and caring for the victims of industrial accidents. The laity should be educated as to the seriousness of even slight

injuries when infected which may cause loss of eyesight or eyeball. In "Work-Accidents and the Law" (the "Pittsburg Survey"), Crystal Eastman has shown that of eleven men who lost an eye, three received nothing as compensation and all $623 or $56.63 average for each eye. This kind of investigation calls attention to the need of proper compensation laws and several states now have commissions investigating the compensation of workmen for their injuries. Montana has passed a law, (1909, Chapter 67, Page 81), which has the following for compensation of injuries to coal miners and employees of coal washers. Total or permanent disability includes total loss of eyesight. Compensation monthly, from an insurance fund, of not to exceed a dollar each working day, and if death as a result of injury ensues within one year, $3,000 shall be paid dependants. Loss of one eye shall be compensated in the sum of $1,000.

D. HOW TO SECURE COOPERATION OF EMPLOYER IN PREVENTION OF ACCIDENTS AND DISEASED CONDITIONS

Recently some of our great industries have made tentative plans for the relief or compensation of injured employees. The United States Steel Corporation provided six months' wages for the loss of an eye, plan of relief on trial for one year from May 1, 1910. During the same months the International Harvester Co. tried a plan. For the total loss of sight of one eye they paid three-quarters average yearly wages and for the total loss of both eyes four years average wages but not less than $2,000. An important institution, American Museum of Safety, in charge of Dr. Tolman, has been established in New York and generously supported by American manufacturers. Its purpose, like those in Europe, is to exhibit various devices to prevent industrial and other accidents and several appliances are shown that will be of special service in protecting the eyes. Among them are protective hoods for grindstones in case of breakage, and to prevent particles flying into the eyes; exhaust fans, gasoline and oil lamps, and containers from which these fluids may be poured through a fire without exploding; paper towels, which would appear to be a simple way to eliminate the danger of infection to the eyes in industrial lavatories; protective screens, lenses, etc. With increased public attention to the desirability of preventing industrial accidents in general will come interest in the prevention of the causes of eye accidents and blindness. One of the basic causes of industrial accidents is insufficient or badly distributed illumination. Mr. John Calder has observed that there is an increased percentage of accidents each year during November, December and January, the months of minimum daylight, especially in the years of greatest prosperity when more work is done by artificial light. Over-illumination of certain parts with surrounding darkness or shadows, imperfect diffusion, is a common cause of accidents, eye fatigue and lowered human efficiency, always a wasteful attempt at saving.

The resulting agitation for and securing of better legislation dealing with the compensation of injured employees will further excite the interest and cooperation of the already usually willing employer to provide safety appliances, danger signals and rules for the protection of the employee. Manufacturers and transportation companies find prevention of accidents important in not only protecting the employees but their own goods and machinery, preventing the loss of services, cost of care, expense of treatment of the injured employee and making litigation and damage suits unnecessary. It is a profitable as well as a humane policy to make factory work as safe and healthful as possible and thus secure better contented workmen, really placing less burden on the ultimate consumer who necessarily has to support the victim of industrial accidents. One great item in lowering the cost of production lies in lessening these accidents.

E. HOW TO SECURE ACTIVE COOPERATION OF THE EMPLOYEE

The most difficult problem is how to secure the cooperation of the employee. He becomes accustomed to his danger, lays aside his protecting lenses when they become soiled or studded with hundreds of abrasions caused by flying particles, etc., as a hindrance in his work, accepting the risks which he too often underestimates. Employees reluctantly use protective appliances unless frequently watched and warned. The United States Steel Corporation is doing splendid work, in providing safety appliances, rules and signs in the various languages of their employees, and have special departments of safety which have successfully secured the cooperation of their employees in the prevention of accidents. See "Work-Accidents and the Law" (Crystal Eastman, Russell Sage Foundation Publication). Undoubtedly much can be done to secure the cooperation of the employee by educating him as to the danger of neglect of certain precautions, and if pressure is properly applied by employer and fellow workmen in the interest of all concerned, the workman's too frequent indifference to safety appliances should soon disappear.

MARK D. STEVENSON, Chairman.

Report of the Committee on Scientific Research

The report of the Committee on Scientific Research was called for and, in the absence of the Chairman, was read by the Secretary. It was referred to the Reference Committee and was as follows:

To the Members of the House of Delegates of the American Medical Association.

Your Committee on Scientific Research would report that it has made for the current year four grants of $200 each for work to be reported at the meeting at Los Angeles as follows:

I. Dr. R. M. Pearce of Philadelphia for the following pieces of work:
   1. Studies of Experimental Bland Infarction. H. T. Karsner and J. H. Austin.
   2. The Relation of Toxic Doses of Horse Serum to the Protective Dose of Atropin in Anaphylaxis. H. T. Karsner and J. B. Nutt.

II. A grant to Dr. E. C. Rosenow, of Chicago, for work on Autolysis of Pneumococci.

III. A grant to Dr. Mary Rawley Lawson of Boston, for work on The Development of the Tertian Malarial Organism.

IV. A grant to Dr. Karl K. Koessler, of Chicago, for work on Antibodies in Scarlet Fever.

Some other applications made could not be granted on account of the time of application, and the committee has, as in the past, restricted its grants to individuals who give reasonable promise of some useful contribution.

ALFRED STENGEL, Chairman.

Report of the Committee on Davis Memorial Fund

The report of the Committee on Davis Memorial was next presented, being read by the Secretary in the absence of the Chairman. It was referred as usual and was as follows:

To the Members of the House of Delegates of the American Medical Association:

Last year I tendered my resignation as chairman of the Davis Memorial Committee to your honorable body. Until very recently I had supposed it had been accepted, when your President wrote me to the contrary and asked for a report.

I beg to suggest that this may be considered final. I acknowledged last year, in my report, a disappointment that was in a measure humiliating, that your committee was unable to report a better success. I would suggest that a memorial letter be issued by the House of Delegates to the different state societies, asking a special appropriation for this worthy object. Massachusetts and Iowa are to be excepted, since they have already contributed liberally.

The Association itself voted conditionally to contribute $500. In view of this I would suggest: (1) that the chief hall in the new building be dedicated to the memory of Dr. Davis as the Nathan S. Davis Memorial Hall; (2) that a bronze bust of Dr. Davis be placed in the hall, this to be paid for out of the funds already in the treasury; (3) that such portion of the fund as remains be designated the N. S. Davis Lecture Fund, the income of which shall be used for this purpose, as the Trustees of the Association may designate.

HENRY O. MARCY, Chairman.

Report of the Council on Medical Education

Dr. Arthur D. Bevan, Chicago, Chairman, presented the report of the Council on Medical Education as follows. It was referred to the Reference Committee on Medical Education.

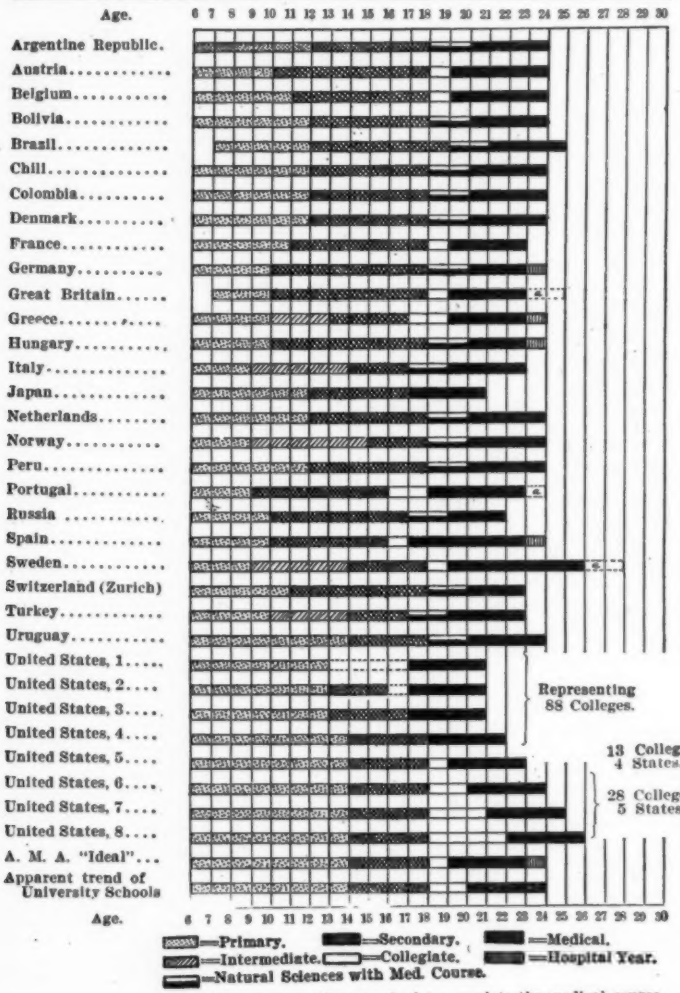
To the Members of the House of Delegates of the American Medical Association:

STUDY OF MEDICAL EDUCATION

The Council on Medical Education has now devoted seven years to the study of medical education. Not only has this been done through the obtaining of valuable data from all pos-

sible sources, but the investigation included at least two thorough, personal inspections of every medical school in the United States. As a result of this study, two classifications of the medical colleges of this country have been reported. The first, a preliminary classification, was presented in 1907 but was not published. The second classification, which was based on a more complete investigation, was reported last year, and, in accordance with the instructions of your honorable body, was published in THE JOURNAL of the American Medical Association, June 18, 1910.

CHART 1.—PRELIMINARY AND MEDICAL EDUCATION AT HOME AND ABROAD



a Shows average time required to complete the medical course.

ANNUAL CONFERENCES

Another special feature of the Council's work has been the seven annual conferences on medical education, which were largely attended by members of state medical licensing boards, deans of medical schools, presidents of universities, and other prominent educators. Through these conferences, many educational problems have been given thorough discussion, reasonable standards have been fixed and more united and effective work by educational agencies has been brought about.

A MODEL MEDICAL CURRICULUM

At the conference held in 1909, a special committee consisting of one hundred prominent medical educators of the United States and Canada, after a prolonged study of the problems involved, brought in an exhaustive report regarding the subjects contained in the course of study in our medical schools and recommended a "model medical curriculum." The report of this special committee has been widely circulated among medical educators and is still in great demand.

REGULAR WORK AND DATA COLLECTED

Besides the special activities carried on by the Council during the last seven years, there are many regular lines of work which have been followed from the beginning, by means of which an abundance of valuable data bearing on medical education has been collected and kept up to date in permanent files.

(a) Reports from state medical licensing boards have been obtained regarding applicants examined for license to practice medicine. Besides giving considerable personal information, the reports give the college and year of graduation of each applicant, and a statement as to whether he passed or failed. Complete lists of those previously licensed were also obtained from each state, so far as the state records permitted. The Council has in a permanent file, therefore, a complete list of those licensed in all states, and is keeping this file up to date by obtaining reports of all examinations within a short time after they are held.

(b) The Council has likewise received each year from all medical colleges lists of those who graduated as well as data regarding their medical students. Complete alumni lists have been obtained not only of all existing colleges, but also of the majority of colleges which have long since become extinct. The Council has in a second permanent file, therefore, a fairly complete list of the alumni of the medical colleges in the United States and Canada, and is keeping this file up to date by obtaining regularly the lists of all new graduates.

(c) In addition to the information obtained from medical colleges and from the state boards, personal information regarding the place and year of birth, preliminary and medical education, etc., is obtained from physicians themselves. On the basis of the official and personal data thus obtained a biographical card index of all the physicians in the United States, arranged in alphabetical order, has been established. This file also is being kept up to date by the addition of new names as fast as the evidence of their having been licensed is obtained.

(d) In accordance with the instructions received last year from your honorable body, the Council has established an index file of the medical students in the United States. Lists of their matriculants have been received from a large majority of the medical colleges. As soon as a student graduates, his card will be transferred to the biographical index, described in the last paragraph. A record is now being kept of each physician, therefore, from the time he enters on the study of medicine.

(e) A permanent file is also kept of the announcements of medical colleges, both domestic and foreign. This file is kept up not only by the addition year by year of the new announcements as they are issued, but also back numbers are being received relating both to existing and to extinct colleges.

(f) Permanent files are also kept for announcements of secondary schools, colleges of liberal arts, transactions of other educational agencies, educational pamphlets, etc.

It is safe to say that there has been an abundance of valuable information collected by the Council which is not to be found anywhere else. In fact, by means of the data as outlined the Council is in position to answer the rapidly increasing number of inquiries regarding educational matters which are received by every mail.

EDUCATIONAL STANDARDS ABROAD

In 1908 a special study was made by the secretary of educational standards abroad and the requirements of nineteen

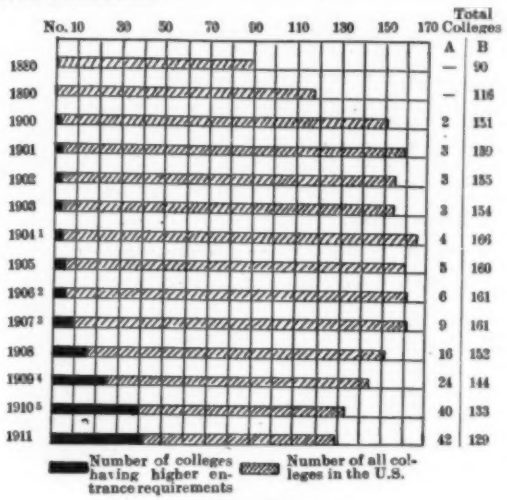
countries of Europe and South America were shown in comparison with those of the United States. In the same year, what was probably the first complete list of the medical colleges of the world, was also published. It is doubtless this comparative study of the educational standards which has received special mention abroad and which caused the Council on Medical Education to be listed by Dr. P. J. Eijkman,[1] of The Hague, among the organizations of the world which are exerting an international influence on the standards of medical education. Meanwhile, facts regarding educational standards and permitting of graphic comparison have been received from twenty-five of the countries of Europe, Asia and South America. These standards are shown in Chart 1, in comparison with the standards enforced in the United States.

PROGRESS IN MEDICAL EDUCATION

As to the improvements which have been made in medical education, it should be said that more has been accomplished in the last six or seven years than in the previous sixty years. It may not be fair to say that all has been brought about by

CHART 2.—MEDICAL COLLEGES IN THE UNITED STATES

Showing the totals in the years given of (A) colleges requiring for admission one or two years of college work, and (B) all colleges in the United States.



REFERENCES

1. The Council on Medical Education was created in 1904.
2. The first personal inspection of all medical colleges was made by representatives of the Council in 1905-6 and 1906-7.
3. The first classification of medical colleges by the Council was presented to the House of Delegates of the A. M. A. in 1907.
4. Second tour of inspection of all medical colleges by the Council was completed, 1909-10.
5. Second classification of medical colleges reported to the House of Delegates and published, 1910.

the work of the Council on Medical Education, nevertheless, it is clear that action taken by a national body such as the American Medical Association, representing as it does the organized medical profession of the United States, was sure to have an extensive influence. So the positive campaign carried on by your permanent committee on medical education has given impetus to a nation-wide movement for better educational standards, which, by uniting and reenforcing the activities of other agencies, has resulted in the progress which we are permitted to report to-day.

IMPROVEMENTS IN RECENT YEARS

Since 1904 changes for the better in medical education have been particularly rapid. Up to that year the number of medical colleges, most of which were conducted for profit, continued to increase regardless of the growing demand for better medical schools rather than a larger number. In 1904 the maximum number of 166 medical colleges had been reached, constituting, to use a phrase made possible by the Council's researches, practically one-half of the world's supply.

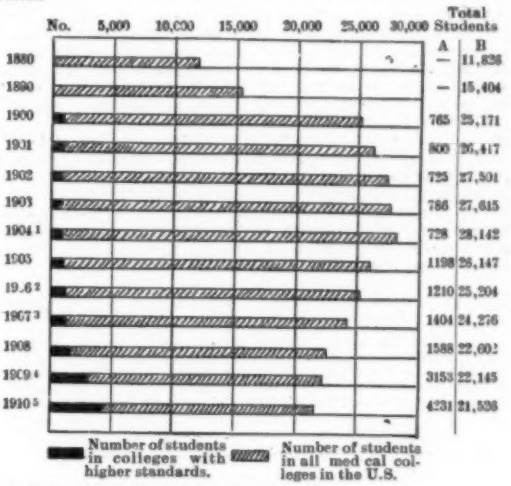
1. See THE JOURNAL A. M. A., Aug. 6, 1910, p. 508.

FEWER BUT BETTER COLLEGES

Since 1904, however, there has been at first a gradual and then a positive decrease in the number of colleges until now the number has been reduced to 129. It is significant that the positive decline has been since 1907, when the classification of medical colleges, based on the Council's first actual

CHART 3.—MEDICAL STUDENTS IN THE UNITED STATES

Showing the totals in the years given in (A) colleges having higher entrance requirements, and in (B) all colleges in the United States.

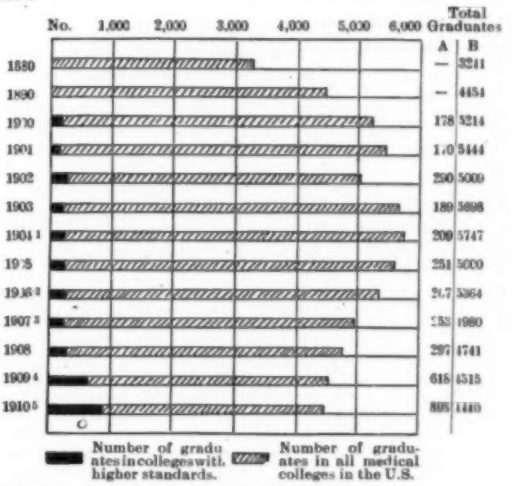


1-5. See reference notes beneath Chart 2.

inspection of all the medical colleges of the United States, was read at the third annual conference. Of the forty-four colleges closed since 1907, twenty colleges were closed outright and twenty-four merged with others. Of the twenty which became extinct, sixteen had been rated in Class C. This

CHART 4.—MEDICAL GRADUATES IN THE UNITED STATES

Showing the totals in the years given in (A) colleges having higher entrance requirements, and in (B) all colleges in the United States.



1-5. See reference notes beneath Chart 2.

decrease, therefore, has been due to the closing of the weak and inferior colleges or by the merging of two or more medical colleges, forming in practically every instance one stronger and better equipped college. Instead of being a serious matter, therefore, this decrease in the number of medical colleges has been of positive benefit, resulting as it has in the forma-

tion of better colleges and in the elevation of educational standards. Since 1904 there has likewise been a decrease in the number of medical students and medical graduates.

COLLEGES CLOSED SINCE 1907

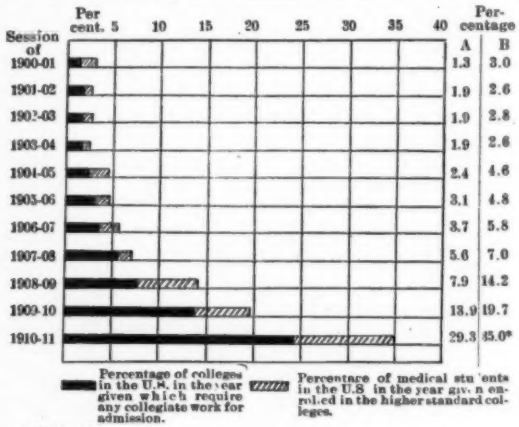
How Closed	Class A	Class B	Class C	Totals
By merger	11	10	3	24
Extinct	..	4	16	20
Totals	11	14	19	44

BETTER STANDARDS OF ADMISSION

Not only has there been an improvement in the standards of medical education since 1904 through the elimination of weaker colleges, but, on the other hand, there has been a decided advance in the standards of admission. Until 1904 only three, or 1.9 per cent., of all medical colleges, were requiring for admission more than a high-school education, but since 1904 the number has increased until now forty-two, or 32.6 per cent. (nearly one-third), of all colleges are requiring for admission one or more years of collegiate work in addition to the high-school course, and medical teaching as a whole has been placed more largely on a university basis. Another fact, however, brought out in Chart 5, is that, although only about 14 per cent. of the colleges held to higher admission requirements during the session of 1909-10, those colleges enrolled about 20 per cent. of all students.

CHART 5.—HIGHER STANDARD MEDICAL COLLEGES IN THE STATES AND STUDENTS ENROLLED

This chart shows the increase by percentages in the number of higher standard colleges and also the increase in the enrollment of students in such colleges. The figures show in the year given (A) the percentage of all colleges holding higher entrance standards, and (B) the percentage of all students enrolled in these colleges.


Session of
Per cent. 5 10 15 20 25 30 35 40
Percentage A B
1900-01 1.3 3.0
1901-02 1.9 2.6
1902-03 1.9 2.8
1903-04 1.9 2.6
1904-05 2.4 4.6
1905-06 3.1 4.8
1906-07 3.7 5.8
1907-08 5.6 7.0
1908-09 7.9 14.2
1909-10 13.9 19.7
1910-11 29.3 45.0*
Percentage of colleges in the U.S. in the year given which require any collegiate work for admission.
Percentage of medical students in the U.S in the year given enrolled in the higher standard colleges.

* Estimate.

COLLEGES AND STATES HAVING HIGHER REQUIREMENTS

The twenty-eight medical schools which are now requiring as a minimum for entrance two or more years of work in a college of liberal arts in addition to a four year high-school education are as follows:

College	Began
Johns Hopkins University, Medical Department	1893
Harvard Medical School	1900
Western Reserve University, Medical Department	1901
University of Chicago, Rush Medical College	1904
University of California, Medical Department	1905
University of Minnesota, College of Medicine and Surgery	1907
University of North Dakota, College of Medicine	1907
University of Wisconsin, College of Medicine	1907
Cornell University Medical College	1908
Wake Forest College, School of Medicine	1908
Leland Stanford Junior University, Department of Medicine	1909
Yale Medical School	1909
University of Kansas, School of Medicine	1909
University of Michigan, College of Medicine	1909
University of Nebraska, College of Medicine	1909
University of South Dakota, College of Medicine	1909
University of Colorado, School of Medicine	1910
Indiana University School of Medicine*	1910
State University of Iowa, College of Medicine*	1910
State University of Iowa, College of Homeopathic Medicine	1910
Drake University College of Medicine	1910
University of Missouri, Department of Medicine†	1910
Dartmouth Medical School	1910
Columbia University College of Physicians and Surgeons	1910
Syracuse University College of Medicine*	1910
University of Pennsylvania, Medical Department*	1910
University of Utah, Medical Department*	1910
Northwestern University Medical School‡	1911

* One year required for the session of 1909-10.
† One year has been required since 1906.
‡ One year required since the session of 1908-09.

The thirteen following colleges require in addition to a four year high-school course one year of work in a college of liberal arts.

College	In Force
Howard University School of Medicine	1910
Kansas Medical College	1910
Tulane University, Medical Department	1910
St. Louis University School of Medicine	1910
University Medical College, Kansas City	1910
Washington University, Medical Department*	1910
University of North Carolina School of Medicine	1910
Ohio-Miami Medical College, University of Cincinnati	1910
University of Oregon, Medical Department	1910
University of Texas, Medical Department	1910
University of Virginia, Department of Medicine	1910
Fordham University School of Medicine	1911
University of Pittsburg, Medical Department	1911

* Will require two years in 1912 and thereafter.

Four other colleges have stated in printed announcements that one year of collegiate work in addition to a four year high-school education will be required for admission beginning in 1912. These are:

Boston University School of Medicine.
Medical School of Maine.
University of Michigan, Homeopathic College.
University of Vermont, College of Medicine.

From the fact that forty-five medical colleges have adopted higher entrance requirements it is interesting to note that nine state examining boards have also adopted preliminary requirements in advance of a four year high-school education. These are as follows:

State Examining Board of	No. of Years Required.	Affects Students Matriculating.	Affects All Applicants.
North Dakota	2	1907-08	1911
South Dakota	1	1907-08	1911
Iowa	2	1907-08	1911
Minnesota	2	1908-09	1912
Colorado	1	1908-09	1912
Colorado	2	1910-11	1914
Connecticut	1	1910-11	1914
Kansas	1	1910-11	1914
Indiana	1	1909-10	1913
Indiana	2	1910-11	1914
Utah	1	1910-11	1914

There are several other states which are contemplating similar increases in their requirements in the near future.

OTHER IMPROVEMENTS

In the last seven years, however, other radical improvements in medical education have taken place. College terms have been lengthened, new methods of teaching have been adopted, more salaried teachers have been employed, more endowments secured, new buildings erected, better laboratories and laboratory equipment installed and better hospital connections and clinical facilities secured. The last year particularly has witnessed many remarkable changes for the better in medical education. Several of our larger medical schools have received large donations, have been thoroughly reorganized, have secured or built teaching hospitals and have adopted higher standards of admission. And reports of other changes of similar importance continue to come in.

BETTER STANDARDS OF LICENSURE

The progress for higher standards, however, has not all been confined to the medical colleges. The requirements of state medical licensing boards have likewise been considerably advanced. The statement regarding these changes is based on a careful study of the practice acts and board rulings and on correspondence received from the officers of the various boards, giving their interpretation of the laws they have been appointed to enforce.

1. In 1904 apparently only twenty states had any provision in their medical practice acts for preliminary education, now thirty-six have that provision. Then only ten states required a standard four-year high-school education as their minimum standard, and none required any college work. Now thirty-one states require the standard high-school course and nine of these require one or two years of collegiate work in addition. Then only four states conducted preliminary examinations and

inspected credentials previous to or at the time of matriculation. Now nine states perform those duties.

2. In 1904, thirty-six states required that all candidates for license be graduates of legally chartered medical colleges; now forty-four states have the requirement.

3. In 1904, forty-five states required an examination of every applicant; now forty-eight require an examination.

4. In 1904, the boards of only fourteen states had authority to refuse recognition to inferior or disreputable medical colleges. Now twenty-eight boards have full authority to refuse such recognition and fourteen others have a limited or divided authority.

5. In 1904, there were thirty-six states each having a single board of medical examiners. Since that year, four more states have secured single boards, making forty at the present time.

6. Reciprocal relations had been established by twenty-seven states in 1904 with two or more other states; now thirty-four states have such relations, and in four other states, Alabama, Oklahoma, South Dakota and Pennsylvania, the boards have the authority to establish such relations if they care to do so.

7. Since 1904 six state boards have initiated practical tests to a certain extent at their examinations, thus making it possible to differentiate between applicants who have gone through a mere cramming process and those who have had a thorough medical training in laboratory and clinic.

ADVANCES IN STATE LICENSE REQUIREMENTS IN SEVEN YEARS

Requirement or Provision	States Having Provision for			States Still Having No Provision for
	In April 1904	In April 1911	Increase	
Any requirement of preliminary education	20	36	16	13
A standard four-year high school education	10	31	21	18
One or two years of college work as a minimum	0	9	9	40
Inspection of all credentials at time of matriculation and control of preliminary examinations	4	9	5	29[1]
That all applicants be graduates of a medical college	36	44	8	5
That all applicants undergo an examination for license	45	48	3	1
Requirement of practical tests in the license examinations	1	6	5	43
Full authority by boafd to refuse recognition to low-grade colleges	14	28	14	21
Reciprocal relations with other states	27	38	11	11
Single boards of medical examiners	36	40	4	9

1. Eleven states have no medical colleges and therefore no need for this provision.

Relating both to colleges and to state boards, all the changes referred to above have been brought about with a free will and an enthusiasm which constitute the best guarantee that other improvements are to follow and that the shortcomings in our systems of medical education and licensure will be corrected. In order that future work to that end may be directed more effectively, a brief statement of the present conditions is desirable.

IMPROVEMENTS STILL NEEDED

In regard to preliminary education: There is an endless number of agencies having to do with the valuation of the entrance credentials of those who are to enter on the study or practice of medicine and nearly as great a variety of standards and methods are employed. While some of these agencies are conscientious and use examinations or other methods which actually insure that the applicant has the required education, others are not so strict and still others make a farce of the whole matter. In the last instance entrance requirements may have been adopted without any intention of having them enforced. There would be a decided improvement if the number of these agencies could be reduced, if work could be placed in the hands of experts and if all agencies would cooperate for the enforcement of fair standards. This would be of positive benefit not only to medical education but also to the other departments of education.

EDUCATIONAL SAFEGUARDS FAULTY

Under the methods and conditions which still exist, there is scarcely a person so ignorant that he cannot gain admission to a score or more of medical colleges in this country, and he can find some "examiner" who will grant him a "certificate" which is supposed to represent the "equivalent" of a four year high-school education. So long as an applicant can pay the required fee, there are still colleges which are only too glad to accept him, regardless of his lack of preliminary education. With some few exceptions, such colleges are also deficient in regard to expert teachers, laboratory equipment and clinical facilities. In fact, if they could, and did offer a modern medical course, the majority of their students would be incapable of profiting by it.

BETTER LEGAL SAFEGUARDS NEEDED

Of course the low-standard colleges referred to can exist only in states where the laws regulating the practice of medicine are inadequate or are not enforced. The statement is true that a rigid enforcement of the requirement that every student, before entering on the study of medicine, must have secured an education at least such as is given in a standard four year high-school, would force the majority of these inferior colleges to close their doors. The state board should have the right to refuse recognition to any medical college which is deficient either in preliminary requirements or in its laboratory and clinical facilities. Even without such a provision, however, the state board has another effective means of defending the people of its state against ill-trained doctors, and that is through the examination. At present the examination as conducted in the majority of states can be easily passed by the student whose preparation has been based largely on questions asked by state boards, who may have undergone merely a cramming in a quiz class or compend. The most effective remedy is the adoption of practical tests in the examinations by which the student's skill in laboratory methods and in the examination of patients may be proved.

PRACTICAL EXAMINATIONS IN GERMANY

There is much we can learn from the methods employed in the countries of Europe which have had to cope with the same problems with which our states have to deal. In Germany[2] the examination for license comprises written and practical tests in anatomy, physiology, general pathology, pathologic anatomy, surgery, medicine, obstetrics, gynecology, ophthalmology and hygiene. There is also a clinical part of the examination in which the candidate, on one day has to examine a medical patient in the presence of the examiner, and on the next day a surgical patient, giving for each the etiology, diagnosis, prognosis and treatment, immediately after which he draws up a report which is countersigned by the examiner. On the same day in which he examines each case, the student prepares a critical report at home, which is presented to the examiner next morning, with the date and the candidate's signature affixed. For the next week he has to visit both patients once or twice daily. He must keep an accurate account of the progress and treatment of the disease, and in case the patient dies within the seven days he must give a written opinion of the cause of death. Clinical examinations somewhat similar are required also in ophthalmology, obstetrics, pediatrics and mental diseases. Passing in these varied tests qualifies the candidate to practice medicine, but after two rejections no candidate can enter for another examination except in very special cases.

PRACTICAL EXAMINATIONS IN GREAT BRITAIN

An excellent system of practical examinations has been developed in Great Britain by the conjoint board in London, according to Mr. Abraham Flexner, who has just made a prolonged investigation of medical education abroad. It is stated that as many as 150 to 200 candidates appear at each examination. Everything needed for the examination is brought to the examination hall. The museums of London furnish the needed surgical and pathologic specimens; the hospitals and out-patient departments furnish patients. The examinations are conducted entirely by teachers and some of the ablest men in England regard it as a public duty to serve in that capacity. In the examination witnessed by Mr. Flexner, every student was examined by two teachers. The examination was both written and practical, and the written papers were marked independently by two teachers. In a large number of papers thus marked no great variation in the markings by the two examiners were found. The examinations as now conducted by the conjoint board in England have been developed by Mr. Frederick G. Hallet, the secretary of the board. Meanwhile, it is hoped that the Council on Medical Education can induce Mr. Hallet to attend the conference on medical education to be held next February, and explain more in detail how the system works, to the many delegates of state licensing boards who will be in attendance at that conference.

2. Brit. Med. Jour., June 3, 1905, p. 1197.

GIVE THE STATE BOARDS A FAIR CHANCE

The solution of many of the problems of medical education rests in the hands of the state licensing boards, and doubtless will be solved by them if they are given a fair chance. In many of the states, however, the medical boards are seriously handicapped. As a rule, the board is too closely connected with politics and in some states the members are appointed for political reasons and, therefore, are liable to be changed with every turn of politics. It is often difficult, therefore, to secure the best men for membership on the boards. Again, the boards are often hampered by lack of funds to do what could and should be done. Too often they must depend on the fees received from applicants, in which case a strict enforcement of fair standards tends to reduce the number of applicants and correspondingly the financial resources of the board. Furthermore, in several states the board is not given full authority in the premises. Either they are handicapped by a very poor practice act, or their authority is limited or divided by the establishment of special boards for the various medical sects, which makes impossible a really satisfactory regulation of the practice of medicine. As has been frequently pointed out, there are in the fifty states and territories of the Union some sixty-five different licensing boards, or eighty-three if we count also the seventeen boards which have been granted to osteopaths. At most there should be but one board in each state, and that board should be composed of men appointed for their particular skill in the examining and licensing of physicians and not for political reasons. Furthermore, the board should be a permanent body so that after the members have become experienced the public may have the benefit of that experience. There are some boards which change secretaries every few months or year, when the records and the work go into the hands of someone who may be entirely without experience in the work involved. If possible, the board should have a permanent secretary, who will hold his place during good behavior, and who is not subject to removal with every change of politics.

ONE PORTAL TO THE PRACTICE OF MEDICINE

Not only should there be but one board in each state manned by able examiners, but there should be a single educational standard fixed with which every applicant for a license to treat the sick, by whatever means or method, should comply. Let there be one portal of entry to the practice of medicine. The statement is a repetition but it will bear repeating, that all who are to treat human ailments, no matter whether they are regulars, homeopaths, osteopaths, or the followers of any other school, are alike in that *they must make a diagnosis;* they must be capable of differentiating between the various diseases in order to intelligently treat the cases which may come to them and, therefore, they should all be required to have a training in the fundamental medical branches.

Even with a single board and a single educational requirement in each state, there would still be considerable confusion in methods and in standards as compared with the regulation of the practice of medicine in other countries where a single authority is in control and where ample funds are provided with which to do things. Much of the difficulty in this respect, however, can and is being offset through cooperation between boards. But much remains to be done to extend this cooperation and to secure more uniformly high standards and more uniformly thorough methods of examination.

But as already stated, progress is being made all along the line and will continue to be made. In many of our states, however, it is necessary to secure the enactment of better medical practice acts, and that is usually a slow process. Nevertheless, the needs are pretty generally known, the facts are being given publicity, and it will not be long before the public will demand the adoption of satisfactory laws and a better regulation of the practice of medicine. Ignorance, pretense and quackery should no longer be tolerated on the part of those who are to enter on the practice of medicine.

THE AMERICAN STANDARD OF MEDICAL EDUCATION

It is now clear to those who are familiar with the situation that a satisfactory medical training in accordance with the known facts of modern medicine requires: (a) A training in a good secondary school; (b) a premedical course of one or two years devoted to the sciences of physics, chemistry and biology, and to modern languages; (c) a four year course in a modern medical school which has ample laboratory, museum, library, dispensary and hospital facilities, and which has a sufficient number of expert, full time teachers, and (d) a year spent as an intern in a good hospital. We believe that is the minimum training by which it is possible to prepare a student for independent practice. This means a training covering six years after the completion of the high-school course. While it is evident that this requirement cannot immediately be put into effect throughout the whole country, nevertheless, it should be emphasized that anything short of this as an ultimate requirement is clearly insufficient. A comparative study of medical education abroad shows that this is the only large and important country in which the above requirement as a minimum is not insisted on. We believe, therefore, that the American Medical Association should urge each state board and each medical school to adopt these requirements just as soon as their environments will permit. Furthermore, we believe the time is now here, when state boards should adopt the requirement that every applicant must have spent a fifth year as an intern in some good hospital.

RECAPITULATION

The following will briefly summarize the statements presented in the report:

Work of the Council

(a) The Council has now spent seven years in the study of conditions underlying medical education and the licensing of physicians.

(b) An abundance of information relating to all phases of education but more particularly to medical education has been collected. Much of the information collected cannot be obtained anywhere else.

(c) The Council on Medical Education has been listed by Dr. P. J. Eijkman of The Hague, among the organizations of the world which are exerting an international influence on educational standards.

(d) The Work of the Council and of the American Medical Association have been effective in bringing about marked and rapid improvement in medical education during the last seven years.

Advances in Seven Years

(e) The number of medical colleges in the United States has been reduced from 166 in 1904 to 129 in 1911. This reduction has been due to the closing of poor schools or to the merger of two or more colleges, forming in each instance one invariably stronger and better medical school.

(f) Medical schools requiring one or more years of collegiate work for admission have increased from four in 1904 to forty-two in 1911.

(g) Although the number of medical students in the United States has been reduced from 28,142 in 1904 to 21,526 in 1910, on the other hand the number of students enrolled in high-standard medical colleges has increased from 728 in 1904 to 4,230 in 1910.

(h) In 1904 only 2.4 per cent. of all medical colleges were requiring one or more years of college work for admission, now 32.6 per cent. (nearly one-third) of all colleges are enforcing that requirement.

(i) Since 1904, preliminary educational requirements have been adopted in sixteen more states; a four year high-school education has been made the standard in twenty-one more states, and nine states have adopted as their minimum a requirement of one or two years of collegiate work.

(j) Six state licensing boards are now to a limited extent using practical tests in their state license examinations.

(k) Since 1904, reciprocal relations have been established by eleven more states, making a total of thirty-four which now have such relations with other states.

Advances Still Needed

(l) There are apparently too many agencies passing on the credentials of matriculants to medical colleges, and also an endless variety of methods are employed. The number of these agencies should be reduced to the smallest possible number and the methods should be made more effective.

(m) At the present time any student, however unqualified, can find some "examiner" who will grant him a "certificate" which is supposed to represent the "equivalent" of a four year high-school education.

(n) A more strict enforcement of preliminary standards by state boards would have a beneficial effect by inducing the medical colleges to live up to their published standards of admission.

(o) More thorough and practical examinations should be adopted by state licensing boards so as to differentiate between the candidate who has been trained by quiz-class methods alone from the candidate who has received a thorough training in laboratory and clinic.

(p) An effort should be made by the medical profession of each state to secure the appointment on state medical licensing boards of men who are especially qualified for the duties devolving on them.

(q) There should be in every state only one portal to the practice of medicine. All who are to treat human ailments, regardless of their "methods of treatment," are alike in that *they must make a diagnosis.* Unless they know what the patient's trouble is, any treatment is mere guesswork, unscientific, and as liable to do harm as good. To be able to make the proper diagnosis requires a thorough training in the fundamental medical sciences, and this training should be required of all alike.

(r) To master thoroughly the modern medical course requires: (1) a training in a good secondary school; (2) a premedical course of one or two years devoted to the sciences of physics, chemistry, biology and a modern language; (3) a four-year course in a modern medical school having well-equipped laboratories and an ample force of expert teachers, and (4) a year spent as an intern in a good hospital.

(s) Finally, it is of great importance that closer relations be brought about between hospitals and medical schools, and that those in charge of hospitals should recognize the educational function of the hospital. Not only is a hospital made more influential by a close association in a teaching capacity with some university medical school, but also its patients are sure to receive better attention, and furthermore, the hospital will be doing a service to the community by helping to develop capable, well-trained physicians.

DEFINITE RECOMMENDATIONS

In order to secure the best results, it is recommended that during the next year all forces working for the betterment of medical education make special efforts along the following lines:

In General

1. Men best qualified for the work to be urged for appointment on state licensing board.
2. Educate the public and legislators regarding the necessity of a single portal of entry to the practice of medicine for the right to treat human ailments by whatever methods.
3. Emphasize the need of private endowment or state aid for medical education.

For Medical Colleges

4. The adoptions, at the earliest possible time, of one or two years of work devoted to physics, chemistry, biology and modern languages in addition to the four year high-school education.
5. The securing of more expert full-time instructors particularly of the laboratory branches.
6. The development of better library and museum facilities.
7. The development of more extended and careful study by senior students of patients in dispensaries and hospitals.
8. The adoption of the requirement at the earliest possible date of a fifth year to be spent by the student as an intern in a good hospital.

For State Licensing Boards

9. Adoption of the requirement that each applicant should possess the higher preliminary qualification as outlined in paragraph 4 above.
10. The provision for a more careful valuation of the preliminary credentials presented by all applicants.
11. The adoption of thorough and practical tests at state license examinations. These are now employed by England, Germany, Hungary, Norway and other leading countries of Europe.
12. The extension of reciprocal relations with other states, but this provision should be safeguarded by a careful scrutiny of the applicant's credentials and by a more strict use of the board's discretionary power.

Respectfully submitted,

ARTHUR DEAN BEVAN, Chairman.
N. P. COLWELL, Secretary.

Ask Congress to Amend Food and Drugs Act

Dr. F. G. Wheatley, Massachusetts, presented resolutions asking Congress to amend the Food and Drugs Act so that false statements of any kind shall be unlawful. This was referred to the Reference Committee on Legislation and Political Action.

Proposal to Reconstruct Judicial Council

Dr. John B. Roberts, Pennsylvania, presented an amendment to the By-Laws to modify the Judicial Council. This was referred to the Reference Committee on Amendments to the Constitution and By-Laws.

On motion, the House of Delegates adjourned until 2 p. m.

Second Meeting—Monday Afternoon, June 26

The House of Delegates convened at 2 p. m., and was called to order by the President. The Secretary called the roll and a quorum was present.

The minutes of the morning meeting were read and approved.

Report of the Committee on Nomenclature and Classification of Diseases

The report of the Committee on Nomenclature and Classification of Disease was referred, without reading,* to the Reference Committee on Hygiene and Public Health. It will appear in THE JOURNAL next week.

Report of the Committee on Scientific Exhibit

The report of the Committee on Scientific Exhibit was referred, without reading, to the Board of Trustees. It was as follows:

To the Members of the House of Delegates of the American Medical Association:

The migration of the Association in its annual sessions offers only an apparent and not a real or serious embarrassment to the success of the Scientific Exhibit. According to the region or peculiar facilities offered at a given meeting place, instructive variety may be given to the character of the exhibit. Thus at New Orleans tropical medicine was given prominence. In Boston the facilities of the Harvard laboratories made possible microscopic and gross demonstrations of extraordinary interest. Last year under the inspiring direction of Dr. Frank J. Lutz, commendable impetus was given to the historical phases of medicine. The geographic position of the present meeting place offers opportunity to emphasize the pathologic and sanitary phases of the plague.

A common fallacy in the minds of those who might exhibit is the impression that only large collections are desired. The small research exhibit to which the gold medal was awarded last year, was offered at a late hour with a modest apology and request that it might be given a corner somewhere. Society and institution collections must necessarily occupy the most prominent place in the exhibit; but small exhibits are equally desirable and sometimes more instructive.

Dr. W. A. Evans, chairman of the Section on Preventive Medicine and Public Health, is to be commended for attempting this year what we have at different times sought to persuade chairmen of sections to undertake, viz.: to coordinate the work of the section with that of the exhibit. The one should supplement the other.

Remoteness of the meeting place has not hampered the success of the Scientific Exhibit to the extent that might be expected. In this as in other matters pertaining to the session, western men have been alert to their obligations. Under the direction of Dr. Stanley P. Black of Los Angeles and Dr. William Ophuls of San Francisco, very excellent contributions have been secured from the coast region. From east of the Rocky Mountains have come no less than nine exhibits.

These facts bear eloquent testimony to the loyalty to scientific ideals of members of the Association throughout the country. It is not possible at this time to refer in detail to the exhibits; nor to give each exhibitor his due meed of praise for the service rendered. We can only say, "Well done, good and faithful." Following the custom of previous years, the committee, in meager recognition of the service of contributors, offers certificates, medals and awards as detailed below.

1. Certificates of Honor, given to only a few of the very superior exhibits.
2. Gold Medal for the best research exhibit dealing with any problem in the fundamental medical sciences.

* These reports were put in type before the session and were printed in the "House of Delegates Handbook." A copy of this is in the hands of each delegate, thus greatly facilitating the course of business. The Handbook also contained the names of all the officers, members of committees, and the Constitution and By-Laws.

3. Gold Medal for the best exhibit on the basis of general excellence, from the standpoint of care in preparation, completeness and instructiveness.

It is recommended that a committee on awards be appointed at once by the president, to pass on the foregoing.

4. Cash Award of $200 for the best series of not less than six original cartoons, dealing with any one or all of the following health problems:

(a) Insects in the Causation of Disease.
(b) Beneficent effects of Animal Experimentation.
(c) Pure Food and Adulterated or Contaminated Foodstuffs.

A considerable number of well-known artists have contested for this award. The exhibit is unique and most instructive. It should be seen by every member of the Association. Out of the two hundred or more cartoons submitted, the Council on Health and Public Instruction should be able to secure quite a number possessing great educational value in promulgating public health propaganda. It is suggested that a committee of three on cartoon contest be appointed at once by the President.

Through the agency of the Scientific Exhibit your committee has always striven to show the newer things indicative of progress in the fundamental branches of medical science. In the work of the sections, the art of medicine has entered more largely. Taken together, they give completeness to the work of the Association.

But we would fall short of duty in this organization did we rest content to promote scientific progress along the narrow lines of the nature, cause and cure of disease. We must harken to the dominant note in our national public life—conservation! It is indeed a fine thing to save the forests, the mines and the water power of the country from wanton destruction; but it is a still greater accomplishment to conserve the health of the people. Just now when the world is awakening to the truth; when statesmen and even the president discuss and commend in enthusiastic terms the public health movement, it is well that the American Medical Association should lay its hand to the plow in this great sanitary field. The Council on Health and Public Instruction has before it problems more difficult and far-reaching than any yet undertaken by the Association. Toward their solution the Scientific Exhibit stands eager to render every possible aid.

It may not be amiss in this connection to recall that the Association was the pioneer in the introduction of public health exhibits, now so generally used in the education of the public. More recently through the agency of the Scientific Exhibit, models were developed for cheap, compact and durable public health exhibits, designed for permanent installation in schools, court houses, village railway stations and like places, where the lessons of hygiene and sanitary science may be taught day by day. Attention has already been called to the health cartoons presented at this meeting.

Many other attractive fields lie untouched. Time is ripe for the infusion of health problems into novels, plays and playlets. Would it be too much for your committee to take the initiative in such a movement? Should this be done, a play dealing with some health problem will be presented a year hence as part of the Scientific Exhibit program.

While your committee has dreamed dreams, it has nevertheless brought some of them to realization. And whether dreaming or doing, we have been spurred on by the hope of accomplishment in a good cause and by your kind sympathy and support, for which accept our thanks.

Respectfully submitted,

FRANK B. WYNN, Director.

Committees on Awards for Scientific Exhibit

In accordance with this report from the Committee on Scientific Exhibit, Dr. Edward Jackson, Colorado, moved that the President be authorized to appoint a Committee on Awards. This was seconded and carried and the President appointed Drs. H. Gideon Wells, Illinois, Chairman; W. E. Musgrave, Philippines, and M. P. Ravenel, Wisconsin.

Dr. C. R. Woodson, Missouri, moved that the Council on Health and Public Instruction be requested to serve as a Committee on Awards for Cartoons. This carried.

The Secretary read a report of progress from the Committee on Anesthesia which was referred to the Reference Committee on Miscellaneous Business.

Report of the Committee on Memorial to Medical Officers Who Died in the Civil War

The report of the Committee on Memorial to Medical Officers who died in the Civil War was received and referred to the Reference Committee on Miscellaneous Business. The report will be published in THE JOURNAL next week.

Report of the Committee on Relief Fund and Physicians' Sanatorium

The report of the Committee on Relief Fund and Physicians' Sanatorium was read by the Chairman, Dr. Edward Jackson, Colorado, and was referred to the Reference Committee on Miscellaneous Business. It will appear in THE JOURNAL next week.

Report of Committee on National Health Organization

The First Vice-President, Dr. E. E. Montgomery, Pennsylvania, then took the chair and called for the report of the Committee on National Health Organization, which was presented by the Chairman, Dr. William H. Welch. The report was referred to the Reference Committee on Legislation and Political Action. The report was as follows:

To the Members of the House of Delegates of the American Medical Association:

At the St. Louis meeting of the Association, 1910, the following resolution was adopted:

Resolved, That the president be and is hereby authorized to appoint a committee of seven members, which shall be charged with the duty of framing a bill for a national department of public health, to be presented to the next session of Congress, in December, and that this committee shall consider and determine all matters and policies relating to national health legislation, and may invite the cooperation and cooperate with other organizations having the same purpose in view, the president of the association, Dr. William H. Welch, to be named as a member of the committee.

Pursuant to the resolution set forth above, the President named the following seven members of the Association to constitute a Committee on National Health Organization: Dr. Hermann M. Biggs, New York; Dr. W. A. Evans, Chicago; Dr. S. G. Dixon, Harrisburg, Pa.; Dr. J. N. Hurty, Indianapolis; Dr. J. N. McCormack, Bowling Green, Ky.; Dr. H. P. Walcott, Cambridge, Mass., and Dr. William C. Woodward, Washington, D. C.

The President of the Association, *ex-officio* a member of the committee, called a meeting of the committee in New York, March 25, 1911, at which time the committee met and organized by the election of Dr. Welch as chairman, and Dr. Woodward as secretary. After a careful consideration of the situation, the skeleton of a bill for the establishment of a department of health was outlined, and the committee adjourned to meet April 1. At that time, the committee again met, and then further developed the outline agreed on at the preceding meeting. A copy of the outline thus developed was submitted to Senator Owen for such use as he might deem proper to make of it in framing a bill to establish a department of health.

At its meeting of April 1, your committee appointed a subcommittee to gather information from various countries with respect to the national health organizations of each, with a view to enabling the committee to perfect its work. This subcommittee is now at work, and the committee expects to gather through it and to digest for the use of the Association and of Congress, information that will be of value in improving the federal health organization of the United States.

WILLIAM H. WELCH, Chairman.

President Welch, in anticipation of the adjournment about to take place, expressed great gratification at the uniform courtesy and helpfulness that had been extended to him by the members of the House of Delegates.

On motion, the house adjourned until 2 p. m., Tuesday, June 27.

[THE PROCEEDINGS OF THE SIXTY-SECOND ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION WILL BE CONTINUED IN THE JOURNAL, JULY 8, 1911.]